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Population and income growth, and a consistent trend toward better health care for all challenges the dental profession to enlarge its productivity by more than one-third. There is substantial evidence that a major resource for increasing the availability of dental health service lies in increased and better utilization of the services of auxiliaries who now support the 98,500 professionally active dentists in the country as follows: (1) There are approximately 116,000 full-time and 28,000 part-time auxiliaries, (2) Within the full-time work force, there are 81,400 chairside dental assistants, 9,700 dental hygienists, 4,300 dental laboratory technicians employed by dentists, and 27,000 dental laboratory technicians employed by commercial laboratories. Initial experimentation indicates that dental educators are competent to train auxiliaries to perform duties beyond those currently accepted as falling within their scope. The revision of state dental practice acts to encourage better utilization of auxiliaries is recommended. Included among appendixes is a state-by-state breakdown of permissible operations by dental hygienists. (JK)

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SUPPLEMENT 1

TO REPORTS OF OFFICERS AND COUNCILS · 1967

AMERICAN DENTAL ASSOCIATION

U.S. DEPARTMENT OF HEALTH, EDUCATION & WELFARE
OFFICE OF EDUCATION

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The Training and Utilization of Dental Hygienists and Dental Assistants

Joint Report of:
Council on Dental Education,
Council on Dental Health,
Council on Legislation

This statement on the training and utilization of dental hygienists and dental assistants is presented as a Joint Report of the Council on Dental Education, the Council on Dental Health and the Council on Legislation since these three agencies, under the *Bylaws* of the American Dental Association, carry responsibilities related to dental auxiliaries.

Introduction: One of the major trends of modern society which already has high visibility in almost all countries of the world is the thrust of people and their governments for health services to which all citizens can have access. In both the well-developed and in the developing countries, this trend is maturing because health is an essential part of a rising standard of living and because there is increasing recognition of the fact that the conservation and improvement of health represents the development of a major national resource from which social and economic benefits will issue. It is a truism that in all programs related to the improvement of total health, dental health must play an essential part.

Trends in the United States: For the past 30 years, since the enactment of the Social Security Act in 1935, the people of the United States and government at all levels have consistently moved toward the provision of better health care for all. The most recent landmark in this effort was the enactment of the Social Security Amendments of 1965 which include the so-called Medicare and Medicaid programs as Title XVIII and Title XIX. There are countless other signs of this trend: the long term program for the construction of hospitals under the Hill-Burton Act, federal aid to education for the health professions, federal aid to group practice facilities, increased federal grants to the states for health, aid for the construction of health-related research facilities, the Community Health Services Act, the Allied Health Professions Personnel Training Act, the Heart, Cancer and Stroke Program and the new

national emphasis on nursing homes. The national drive on the eradication of poverty includes a major emphasis on health reflected in such efforts as Project Headstart and the development of neighborhood health centers by the Office of Economic Opportunity.

The nation's investment in health-related research confirms the magnitude of the effort in the United States. In fiscal 1956, federal funding for health-related research under the National Institutes of Health program amounted to $99,113,000, with $1,078,000,000 budgeted for 1967. In dentistry, appropriations for National Institute of Dental Research sponsored research rose from $2,700,000 in fiscal 1956 to more than $30,000,000 in 1967.

In the private sector, the demand for health services has been greatly intensified by effective programs of health education. In dentistry this trend has been enlarged by the profession's concern with effective dental health education at local, state and national levels, resulting in a growing personal and national appreciation for the importance of dental health and for the dental profession which can assure it.

The rapid and successful growth of programs to prepay the cost of dental care has served materially to enlarge the demand for dental care. As of 1967, 31 constituent societies had established dental service corporations, of which 17 were active, and about 50 commercial insurance companies were developing prepaid dental insurance programs. More than 3,000,000 persons were covered by dental insurance in 1967.

In recognition of these trends and of the need to provide strong and informed professional leadership in programs related to dental health, the House of Delegates of the American Dental Association approved, in 1966 (*Trans.* 1966:306) the American Dental Association Dental Health Program for Children. The Congress will soon provide funds for at least ten pilot projects to initiate this program on a modest basis with the eventual objective of creating the means to provide dental services for all of the nation's children and youth up to the age of 18. This program challenges the imagination and resources of the private sector of the nation and of the dental profession in that programs must be developed to provide dental services for the non-indigent children who are not eligible, and should not be eligible, for federally financed dental health care.

These trends and their persistence are now readily recognized by most dentists—as citizens and as professional men—who are aware that these developments must be informed, guided and led by the best counsel available from the dental profession into channels that will provide a higher level of dental and total health for all people of the nation.

Population and Income Growth: The magnitude of current demand for dental health services will inevitably be intensified by factors which are not subject generally to controls: the growth of the population and the steady rise of personal income. These two factors are expected to cause an increase in demand for dental care, of 38 per cent by 1975 and 60 per cent by 1980, over the 1965 level. The other major factor affecting dental demand is prepayment plans—both private and governmental. Considering all of these factors, total demand for dental services in 1980 is expected to increase 75 to 100 per cent over that of 1965.

The growth of population and demand in the younger age groups will be of particular interest to members of the dental profession. The number of children and youth under age 18 will grow from 77 million in 1970 to 81.2 million in 1975. By

the same year, the American Dental Association Dental Health Program for Children will probably be funded with federal, state, local and private funds on the order of $100 million annually.

Expenditures for Dental Health Care: The trends described are sharply defined in terms of national expenditure for dental health care. Measured in terms of 1957-1959 stable dollars, the public expenditure for dental health care has risen in the past 30 years from $581 million to $2.3 billion. It is estimated that this expenditure for dental health care will be increased by as much as $1 billion by 1975 thus challenging the dental profession to enlarge its productivity by more than one-third.

Present and Future Work Force: Studies by agencies of the American Dental Association show that there are 98,500 professionally active dentists in the United States with 90,000 engaged in private practice. This professional work force is supported by an estimated 116,000 full-time and 28,000 part-time auxiliaries. Within the full-time work force are: 81,400 chairside dental assistants, 9,700 dental hygienists, 4,300 dental laboratory technicians employed by dentists, 27,000 dental laboratory technicians employed in commercial dental laboratories and 20,900 secretaries and receptionists. It is interesting to note that between 1962-1965, the number of auxiliaries increased by 28 per cent, a growth rate 14 times greater than the growth rate for dentists.

It is obvious that the profession's ability to enlarge its productivity by more than one-third by 1975 will depend, in very large measure, on the growth of the professional and auxiliary work force.

Production of Needed Work Force: The number of dental schools has increased from 39 in 1940 to 49 in 1966. In this period, the dental schools were able to expand their first year enrollments by 1,637 students, up to the present high of 3,947. New and expanded construction now underway or in various stages of planning will gradually increase the capacity of the dental schools. By 1975, a minimum of 1,000 additional first year students will be entering the nation's dental schools.

The need for an expanded work force to meet national demands for dental health care can be estimated in another way: the dentist-population ratio. This ratio currently is one dentist per 2,020 of the population. By 1975, with an increase of national population to 223,785,000 and an increase of about 35 per cent in new dental graduates, the dentist-population ratio will be approximately the same as it is in 1967. This is not a reassuring forecast. It can be tempered somewhat by the knowledge that gains will be made in the production of dental care by advancing dental technology, by the application of new research findings and by the benefits of public health measures now being applied to prevent and control dental diseases.

The major, largely untapped, resource of the dental profession to increase the available amount of dental health service will be found in the increased and better utilization of the services of well-trained auxiliaries under the direct supervision of the dentist to perform services which do not require the professional knowledge and skill of the dentist himself. There is substantial evidence, as the following table shows, that the dentist can increase his productivity and the number of patients seen by the use of more auxiliary personnel.[1]

1. *The 1965 Survey of Dental Practice*, American Dental Association Bureau of Economic Research and Statistics, p. 35, Table 57.

Number of Patients and Patient Visits in Relation to Number of Auxiliaries Employed

Full-Time*	Part-Time*	Mean Number of Patients	Mean Number of Patient Visits
0	0	876	2,355
0	1	822	2,298
1	0	1,235	3,015
1	1	1,346	3,323
1	2	1,249	3,850
2	0	1,382	3,946
2	1	1,462	4,083
3	0	1,540	4,409
4 or more	0	2,372	6,170

*"Full-time" means full-time positions occupied all year, and "Part-time" means either part-time positions or positions filled only part of the year.

This increased productivity of the dentist employing auxiliary personnel is confirmed in a 1965 report[2] which relates the mean net and gross income of the practicing dentist to the number of auxiliaries employed.

Mean Income of Non-Salaried Dentists by Number of Auxiliaries Employed

Number of Positions		Mean	Mean	Net as Per
Full-Time*	Part-Time*	Net Income	Gross Income	Cent of Gross
0	0	$11,173	$17,333	64.5
0	1	13,662	23,214	58.9
0	2	17,139	30,752	55.7
1	0	16,916	29,612	57.1
1	1	19,729	35,759	55.2
1	2	21,931	42,994	51.0
2	0	23,405	43,737	53.5
2	1	25,512	50,720	50.3
2	2	26,485	50,426	52.5
3	0	29,531	58,829	50.2
3	1	32,707	63,830	51.2
4 or more	0	37,742	78,034	48.4
All nonsalaried dentists		19,835	36,352	54.6

*"Full-time" means full-time positions occupied all year, and "Part-time" means either part-time positions or positions filled only part of the year.

There is substantial evidence, therefore, that the productivity of the dentist can be materially enlarged by the use of auxiliary personnel working under his supervision. But this potential for increased productivity will never be fully realized unless attenion is given on an immediate and urgent basis to three important factors: (1) an increase in the total number of auxiliaries; (2) better education and training of auxiliaries for enlarged roles in the dental office; (3) the utilization of qualified auxiliaries for expanded assignments in the dental office not requiring the professional competence of the dentist.

Expansion of Training Opportunities for Auxiliaries: There is good evidence that the profession has recognized the need to enlarge the number of dental auxiliaries by expansion of training facilities and opportunities. Dental hygiene schools have increased from 47 to 59 in the period 1963-1967 and 18 additional programs are in the initial stages of development. In the same period, dental assisting programs increased from 38 to 94 and 26 additional programs are now being prepared for an

2. *Ibid.* p. 17, Table 13.

accreditation review by the Council on Dental Education. Five dental laboratory technology programs operating in 1963 have now increased to ten with a maximum of six new programs ready for evaluation in 1968.

Even with this substantial growth in educational and training opportunities, the profession is still far short of the number of auxiliaries needed. A recent study[3] estimates that 5,300 dental hygienists, 15,300 dental assistants and 2,200 dental laboratory technicians should be graduated annually by 1975 in order to maintain the existing ratios of auxiliaries to practicing dentists. This study also points out that, on the basis of a realistic appraisal of present educational and training resources, only 2,800 dental hygienists, 5,700 dental assistants and 400 dental laboratory technicians will be produced in 1975. This will mean a deficit in the dental work force of 2,500 dental hygienists, 9,600 dental assistants and 1,800 dental laboratory technicians by 1975.

This deficit can be viewed with even more concern in the light of the fact that the vast majority of dental assistants and dental laboratory technicians now in the work force have had little or no formal education for their important supporting roles of increasing the dentist's effectiveness and productivity. It is clear, therefore, that auxiliaries must be trained in greater numbers by preparatory training of new personnel and the retraining of existing personnel.

The Council on Dental Education has annually reported to the House of Delegates for the past two decades on the profession's concern over future manpower needs, since a shortage of manpower in meeting a nation's demand for dental care has led, historically, to governmental proposals for the development of sub-professional practitioners. Recent developments in Canada have led to the legalization of "dental mechanics" over the protest of the dental profession. In Great Britain, the shortage of manpower has led to the acceptance of the concept of the New Zealand "dental nurse".

In the United States the concern about health manpower shortages was evident in the passage by the Congress in 1966 of the "Allied Health Professions Personnel Training Act" (P.L. 89-751) whose purpose is to increase the opportunities for training personnel in the allied health professions and to improve the educational quality of the schools training such personnel. Dental hygienists, dental assistants and dental laboratory technicians are included within the provisions of the Act. Both the President of the United States and the Secretary of the Department of Health, Education and Welfare have commented in recent months on the need for training more and better qualified auxiliaries in the health professions to assist in meeting national needs for health care.

Experimental Training Programs for Auxiliary Personnel: In 1960, the House of Delegates of the American Dental Association recognized the potential shortage of dental manpower by encouraging accredited dental schools and training activities of the federal dental services "to undertake carefully designed programs of experimentation and research in the training of dental hygienists and dental assistants" (*Trans.* 1960:208). It should be noted that the House of Delegates foreclosed this type of

3. Dental Auxiliary Fact Sheet. May, 1967. U.S. Public Health Service Division of Dental Health, Washington, D.C. (unpublished).

activity for programs of dental technology. Subsequently, the House of Delegates (*Trans.* 1961:222) adopted the *Statement of Policy Regarding Experimentation in Training and Utilization of Dental Hygienists and Dental Assistants* which has served as the basis of experimentation in four training programs. The results of the Great Lakes Naval Training Center Project were reported to the House of Delegates in 1965 (*Trans.* 1965:45), the results of the Indian Health Service project in *The Journal of the American Dental Association* in 1966[4], the results of the University of Alabama, School of Dentistry and Public Health Service project in *The Journal*[5]. The project at the Public Health Service Center in Louisville is still in progress. In all of these projects, participation by auxiliary personnel was not permitted in the diagnosis of dental disorders, treatment planning, and the cutting or severing of either hard or soft tissues in the oral cavity. In addition and in all instances, cavity preparation was completed only by the dentist. It should be noted that the auxiliaries were assigned tasks which were reversible in nature thus permitting immediate correction if this was necessary. These limitations on the technical procedures which can be performed by an auxiliary were in compliance with Association policy which defines the professional duties of the dentist.

A progress report on the experiment at the School of Dentistry, University of Alabama, will be of interest[6]:

> The seven clinical procedures investigated were inserting amalgam restorations, inserting silicate cement restorations, finishing amalgam restorations, finishing silicate cement restorations, inserting temporary restorations, placing matrix bands, and placing rubber dams. For the various aspects evaluated, the proportions of the clinical procedures judged excellent were consistently greater for the specially trained dental auxiliaries than for dental students. The differences usually were statistically significant. The proportion of procedures graded excellent for the dental students exceeded the corresponding proportion for the auxiliaries for only one aspect. The same proportion was scored excellent for the two types of operators for one aspect. The proportions of unacceptable scores were small, usually favoring the dental auxiliaries but, in an appreciable number of instances, such proportions favored the dental students. All procedures evaluated, whether performed by students or auxiliaries, had been previously judged acceptable by a dentist.
>
> Carefully selected female high school graduates can be trained to perform as well as advanced undergraduate dental students in placing rubber dams; placing matrix bands, inserting and finishing temporary restorations in previously prepared teeth, condensing and carving amalgam restorations in previously prepared teeth; placing silicate cement restorations in previously prepared teeth, and applying the final finish and polish to amalgam and silicate cement restorations.

Conclusions from Experimental Programs: While experimentation on increasing the productivity of the dentist should continue, it seems wholly justifiable at this point to conclude, on the basis of the evidence available, that dental educators are com-

4. JADA 72:386 Feb. 1966.
5. JADA 75:658 Sept. 1967.
6. JADA 75:672 Sept. 1967.

petent to train auxiliaries successfully to perform duties under the direction and supervision of the dentist beyond those which are now generally accepted as falling within their scope.

This is only the half-way point; the dental profession, through the House of Delegates, must now indicate clearly how the results of this research and educational competence can best be applied to dental practice.

The three Association councils presenting this joint report are agreed that the development of further potential for the use of auxiliaries in dental practice rests with the dental profession in the statement of policies by the House of Delegates which will guide and inform further progress.

SCOPE OF DUTIES OF DENTAL AUXILIARIES

The scope of duties which may be assigned to dental auxiliaries is now governed by (1) the policies established by the House of Delegates of the American Dental Association, (2) the *Principles of Ethics* and (3) state laws.

Policies of American Dental Association: For many years the House of Delegates has established policies relating to dental auxiliaries and these have been effective in developing auxiliaries as productive members of the dental health team. In 1966, the House of Delegates, clearly aware of manpower needs and of the necessity of applying research findings relating to auxiliaries to dental practice without undue delay, adopted the following resolution (*Trans.* 1966:341):

> **Resolved,** that it is the responsibility of individual practitioners acting through component and constituent dental societies and state dental examining boards, to proceed promptly with studies, decisions and legislative actions which will help meet the manpower needs of the public, including the identification of additional functions which can be delegated to auxiliary personnel working under the direct supervision of the dentist.

The councils presenting this report believe that the 1967 House of Delegates should reinforce the 1966 action because of the further evidence produced by the experimental studies and because of the urgency of the dental manpower problem. A resolution to achieve this objective is appended to this report.

"Principles of Ethics": *The Principles of Ethics of the American Dental Association* contain the following provision relating to the use of auxiliaries:

> **Use of Auxiliaries.** The dentist has an obligation to protect the health of his patient by not delegating to a person less qualified any service or operation which requires the professional competence of a dentist. The dentist has a further obligation of prescribing and supervising the work of all auxiliary personnel in the interests of rendering the best service to the patient.

It is clear that this provision of the *Principles of Ethics* places directly on the in-

dividual dentist the highest moral obligation of not delegating any service or operation to any auxiliary which requires the professional competence of the dentist. There is no question but that this provision should be rigidly enforced so as to safeguard the health of the patient.

State Statutes: The policies and ethics of the profession in regard to the utilization of auxiliaries are solidly embedded in the state dental practice acts, thus providing legal sanctions against those who fail in this area of their professional obligation. The state laws, however, frequently have the handicap of lack of uniformity thus suggesting to the public a variation in the standards of the dental profession. The state laws, in some instances, are so restrictive as to prohibit assignment of duties to auxiliaries which are acceptable to the dental profession and which are in the interests of a better service to the patient. The state dental practice acts, in many states, are so rigidly drafted that they do, in effect, limit the exercise of professional judgment and competence. Many state laws do not grant to state dental examining boards sufficient regulatory authority to enable them to keep pace with the changes in modern dental practice.

In the field of auxiliary personnel, these anomalies in dental practice acts are most frequently perpetuated by the listing of the specific operations in which an auxiliary may not engage without violating the statute and incurring an appropriate legal penalty. In one state, for example, an auxiliary may be permitted to apply topical fluorides to the teeth; in another, the same procdure is a violation of the law. In one state, a dental hygienist may place her instrument below "the free margin of the gingiva"; in another state, this is a violation of the law. In some states, an auxiliary is permitted to expose x-ray films; in other states this is a violation of the law.

If state statutes are erected to protect the health of the public and to reflect the professional competence of dentists, the conflicting policies and contradictions now embodied in them can only serve to confuse both the public and the profession and to impair the opportunity to render the best possible service to the patient.

In spite of the formidable barriers which are placed by many existing dental practice acts, several states with the assistance of constituent dental societies, have moved forward in the liberalization of that part of their statutes dealing with the duties of auxiliaries: the dental hygienist and the dental assistant. For example, in 1967 Idaho, Kansas and North Dakota amended their state dental practice acts in order to permit dental hygienists, or, as in the case of Kansas, dental assistants to serve more effectively as members of the dental health team under the direct supervision of the dentist. Michigan, by issuance of regulations and not by amendment of the statute, now permits the dental hygienist to take impressions for study models, remove periodontal and surgical packs, remove sutures and polish metal restorations.

An excerpt from the act approved by the State of Kansas on April 10, 1967 indicates the provision made for the exercise of duties by the dental assistant:

> **Sec. 65-1423.** Nothing in this act (Kansas Dental Practice Act) shall apply to the following practices, acts and operations: . . . (g) except as hereinafter limited to the performance of any dental service of any kind by any person who is not licensed under this act, if such service is performed under the supervision of a dentist licensed under this act at the office of such licensed dentist: Provided, however, That such nonlicensed person shall not be allowed to perform or attempt to perform the following dental operations or services:

(1) Any and all removal of or addition to the hard or soft tissue of the oral cavity.

(2) Any and all diagnosis of or prescription for treatment for disease, pain, deformity, deficiency, injury or physical condition of the human teeth or jaws, or adjacent structure.

(3) Any and all correction of malformation of teeth or of the jaws.

(4) Any and all administration of general or local anesthesia of any nature in connection with a dental operation.

(5) A prophylaxis.

In summary, the laws and regulations of the states assign to the licensed dentist the responsibility of providing dental care and, in the case of dental hygiene, specify the services which the dental hygienist may render under the supervision of the dentist. Each of these influences has contributed to the nature and direction of the profession's relations with its auxiliaries and undoubtedly will continue to guide professional policy and practice. It is increasingly important, however, that greater consideration be given to the interrelations of these influences and to the effectiveness with which they are guiding the policies of the profession towards meeting the current and future demands of the population for dental care. The councils submitting this report urge that constituent societies and other involved agencies give renewed attention to the amendment of dental practice acts or issuance of regulations when this is possible to insure that the services of dental auxiliaries can be utilized immediately and effectively by the dental practitioner. In considering such revisions, constituent societies are urged to seek the cooperation of state dental examining boards in procuring legislation which will delete from dental practice acts the detailed listing of permitted operations and will place directly upon the individual dentist the legal responsibility for assigning functions to auxiliary personnel.

It has long been recognized that the delegation of duties by physicians and surgeons to their auxiliaries is in a more advanced stage, professionally and legally, than is dentistry. The success of this effort is attested by public and professional acceptance of physician-nurse cooperation, for example, in rendering a better service to the patient. An excerpt from the "Business and Professions Code" of California (Section 2725) will serve to illustrate this point and its possible application to dental practice acts:

> The practice of nursing within the meaning of this chapter is the performing of professional services requiring technical skills and specific knowledge based on the principles of scientific medicine . . . . and practiced in conjunction with curative and preventive medicine as prescribed by a licensed physician and the application of such nursing procedures as involve understanding cause and effect in order to safeguard life and health of a patient and others.

Enterprise and imagination are needed to apply the experience of medicine and its auxiliary disciplines to the practice of dentistry by revision of the state dental practice acts or through regulation when this is possible.

COMMENT BY COUNCILS

The joint councils are of the opinion that the appropriate revision of dental practice acts, or implementation of existing statutory provisions when this is feasible, will be a major step in reaching the dental profession's objective of providing dental care to all who seek it. In addition, it will enlarge the potential of the dental hygienist and dental assistant as effective members of the dental health team. It will indicate clearly to dental educators the needs of the profession which must be served and it will motivate additional experimentation and research in ways and means of enlarging the profession's production of dental health care. It will provide a useful series of guidelines for the individual dentist in the practice of his profession in place of a series of obsolescent restrictions that invite indifference and infraction. It will clearly acknowledge the competence of the dentist to provide professional guidance and direction to all auxiliary personnel. It will assist in dispelling confusion and misunderstanding on the part of both the public and the profession in regard to the duties assigned to the dentist and his auxiliaries. It will enlarge the capacity of the dental profession to meet the nation's dental health needs.

The joint councils strongly recommend the approval of the following resolution by the House of Delegates.

RESOLUTION

Resolved, that constituent dental societies and state dental examining boards consider recommending revision of dental practice acts (1) to give their examining boards authority to prescribe rules or regulations to achieve more effective utilization of the services of dental hygienists and dental assistants and (2) to eliminate from their acts the serial listing of functions performed by the dental hygienist, and be it further

Resolved, that the state dental examining boards consider the educational standards established by the American Dental Association in determining the qualifications of dental hygienists and dental assistants to perform functions prescribed within rules or regulations of the board.

APPENDIX
BACKGROUND MATERIAL FOR JOINT REPORT OF COUNCILS ON DENTAL EDUCATION, DENTAL HEALTH AND LEGISLATION

The following data and comments are provided in support of the Joint Report on "The Training and Utilization of Dental Hygienists and Dental Assistants".

DATA ON DENTAL PREPAYMENT

Growth of Prepaid Dental Plans: As of December 1966, approximately 3.1 million Americans have prepaid dental care coverage, an increase of slightly more than 1 million, or 55 per cent, over the 1965 enrollment. Dental service corporations showed the greatest growth in coverage with the addition of 575,000 persons, an increase of 126 per cent.

Administrative Mechanism	Number of Eligible Persons				Per Cent Increase 1965-1966
	1960	1964	1965	1966	
Total	732,300	1,469,800	1,988,000	3,089,900	55.4
Dental service corporation	9,000	325,300	458,100	1,033,100	125.5
Commercial insurance company	17,500	274,800	550,600	853,900	55.1
Group practice/clinic	535,600	608,100	616,400	765,900	24.3
5 other mechanisms	170,200	261,600	362,900	437,000	20.4

Since 1960, the number of persons eligible for prepaid dental care has increased fourfold. The number of plans has shown comparable growth, increasing from 155 in 1960 to 632 in 1966.

Status of Prepaid Dental Care in 1966: Twelve of the 15 active dental service corporations administer 180 privately sponsored dental care programs covering 1.0 million persons. Commercial insurance companies have the second largest enrollment based on 110 plans that provide at least minimal benefits including diagnostic services and emergency care. Comprehensive benefits consisting of restorative, prosthetic, and in most instances one or more specialty services are now provided to 2.7 million, or 87 per cent, of the enrollees in prepaid dental plans.

Administrative Mechanism	Number of Organizations	Number of Group Plans	Number of Eligible Persons
Total	169	632	3,090,000
Dental service corporation	12	180	1,033,000
Commercial insurance company	25	110	854,000
Group practice/clinic	78	95	766,000
Self-insured trust	25	25	176,000
Non-profit insurance corporation	1	191	170,000
Mutual benefit association	20	20	35,000
Health service corporation	5	8	16,000
Other	3	3	40,000

In addition to privately sponsored plans, 63 public dental care programs are administered by nine dental service corporations covering 226,000 recipients of public assistance. Approximately 10.8 million persons in 21 states are currently eligible for dental services under Title XIX programs administered by state health and welfare departments. An additional 533,000 children are eligible for dental care under Head Start programs.

Distribution of Prepaid Dental Plans in 1966: The number of privately sponsored dental care plans and the number of persons covered vary widely among individual regions and states. The West has the largest number of persons eligible for benefits; the South has the least adequate coverage. California ranks first among the states in number of eligible persons; New York has the largest number of plans but ranks second in enrollment. Other states with a relatively large enrollment include Illinois and Washington, followed by the District of Columbia, Missouri, and Ohio.

Region & State	Number of Plans	Number of Persons	Region & State	Number of Plans	Number of Persons
Northeast	292	803,800	West	221	1,530,800
New York	247	605,400*	California	160	1,212,100*
Connecticut	8	68,000	Washington	30	223,500*
New Jersey	17	67,200	Hawaii	17	62,200
Pennsylvania	11	25,400	Colorado	5	23,500
5 other states	9	37,800	3 other states	9	9,500
North Central	54	559,400	South	46	173,400
Illinois	8	305,300*	District of Columbia	13	92,900
Missouri	6	88,200	Texas	4	29,200*
Ohio	14	74,700	Maryland	7	20,100
Wisconsin	8	45,300	7 other states	22	31,200
Michigan	8	35,600			
5 other states	10	10,300	Puerto Rico	20	22,600

States with at least one multi-state plan, i.e., one organization underwriting a plan covering eligible members located in more than one state, are indicated above by an asterisk (*).

DATA ON MANPOWER RESOURCES

Supply of Dental Manpower: In spite of the sizable gains in the number of students enrolled in dental schools, the ratio of dentists to population has continued to decline during the past decade and a half. According to the *Health Manpower Source Book,* Section 18, Manpower in the 1960's (Public Health Service, 1964:43) the ratio of dentists to total population dropped from 57.2 per 100,000 in 1950 to 55.7 in 1963. The supply of dentists providing services for the civilian population declined even more sharply. In 1950, there were about 50 active, nonfederal dentists per 100,000 civilians, but by 1963, the ratio had fallen to 45 per 100,000.

Dentists in Relation to Population
July 1, 1950-63*

	1950	1955	1960	1963
Total dentists[1]	87,164	94,879	101,947	105,549
Total population (thousands)	152,271	165,931	180,684	189,375
Dentists per 100,000 population	57.2	57.2	56.4	55.7
Active non-Federal dentists	75,313	76,087	82,630	83,752
Resident civilian population (thousands)	150,790	162,967	178,153	186,626
Active non-Federal dentists per 100,000 civilians	49.9	46.7	46.4	44.9

*Table 25, p. 42, *Health Manpower Source Book, Section 18, Manpower in the 1960's* (Public Health Service 1964).
[1]Excludes graduates of the year concerned, but includes all other dentists, active or inactive.

Although there has been a significant expansion in the number of dental auxiliary training programs, the number is still seriously inadequate to meet the needs of the profession for trained dental hygienists, dental assistants and dental laboratory technicians. Between 1964 and 1965, the number of dental assisting programs increased by 12, the number of dental hygiene programs by six and the number of dental laboratory technology programs by only one.

As a result of a complex of reasons described in the 1966 annual report of the Council on Dental Education, it is anticipated that there will be a continued increase in the number of dental auxiliary programs. Valid estimates of the number of auxiliary programs which may be established during the next five years depend upon several variables which are impossible to assess at present, such as the availability of federal funds for development of vocational-technical education programs, the extent to which community and junior colleges assume increased responsibility for the education of health-related personnel, and the degree to which the dental profession, at the state and local level, promotes the expansion of auxiliary training programs. The following projections on dental auxiliary training capacity have been prepared by the staff of the Council on Dental Education, based upon the assumptions indicated.

Projected Educational Capacity in Auxiliary Education by 1970

Number of Programs	1965	1970
Dental hygiene[1]	56	90
Dental assisting[2]	64	141
Dental laboratory technology[3]	5	30
	125	261

(1) assumes a 10 per cent annual growth rate
(2) assumes a 20 per cent annual growth rate
(3) assumes a 25 per cent annual growth rate

Student Enrollment	1965	1970
Dental hygiene[1]	3,800	6,300
Dental assisting[2]	2,800	6,345
Dental laboratory technology[3]	340	2,040
	6,940	14,685

(1) average of 68 students per school
(2) average of 45 students per school
(3) average of 68 students per school

Accredited Dental Hygiene Schools by Educational Settings

Type of Institution	Number of Institutions
Dental Schools	30
Junior-Community Colleges	14
Four-Year Colleges	10
Vocational-Technical Schools	3
Total	57

Developing Dental Hygiene Schools by Educational Settings

Type of Institution	Number of Institutions
Dental Schools	2
Junior-Community Colleges	9
Four-Year Colleges	4
Vocational-Technical Schools	3
Total	18

Accredited Dental Assisting Schools by Educational Settings

Type of Institution	Number of Institutions
Dental Schools	9
Junior-Community Colleges	47
Four-Year Colleges	4
Vocational-Technical Schools	27
Public Schools	3
Other (hospitals and Public Health Service centers)	4
Total	94

Developing Dental Assisting Schools by Educational Settings

Type of Institution	Number of Institutions
Dental Schools	0
Junior-Community Colleges	13
Four-Year Colleges	2
Vocational-Technical Schools	9
Public Schools	2
Total	26

Accredited Dental Laboratory Technology Schools by Educational Settings

Type of Institution	Number of Institutions
Dental Schools	1
Junior-Community Colleges	4
Four-Year Colleges (University)	1
Vocational-Technical Schools	4
Total	10

Developing Dental Laboratory Technology Schools by Educational Settings

Type of Institution	Number of Institutions
Dental Schools	0
Junior-Community Colleges	2
Four-Year Colleges (University)	1
Vocational-Technical Schools	4
Total	7

Within the past six years, nearly all of the dental schools have inaugurated a dental auxiliary utilization program within their curriculums. The basic objective of this program is to teach the undergraduate dental student to operate effectively with a chair-side assistant. Although research on the results of this program is still in progress, there is evidence available to show that recent dental graduates are, in fact, utilizing the chair-side assistant at an earlier stage in their dental practice and that such utilization increases the number of patients who can be treated. Efforts are underway in several of the dental schools to extend the dental auxiliary utilization (DAU) program to include more extensive experience for the dental student in working with the dental hygienist and dental laboratory technician.

Among the factors which relate to the adequacy of the supply of dentists to meet demands and needs for dental care is the problem of geographic distribution. The latest information available (1963) shows a geographic variation in the ratio of dentists to population of 36 per 100,000 in the Southern part of the country to 68 per 100,000 in the Northeastern section.

Like other health professionals, dentists tend to locate in large metropolitan centers, thus accounting for a substantial variation in the supply of professional manpower between rural and urban areas. In 1962, the dentist to population ratio in greater metropolitan areas (one million or more population) was nearly 70 dentists per 100,000 population. Isolated rural areas (counties containing no village of more than 2,500 persons) had a ratio of 27 dentists per 100,000 population.

According to the *1965 Survey of Dental Practice,* there were approximately 136,300 full-time dental auxiliaries providing services to dentists in active practice. By category of auxiliary service, there were 81,400 dental assistants; 20,900 secretary-receptionists; 9,700 dental hygienists; 4,300

dental laboratory technicians employed in dental offices, and an estimated 20,000 dental laboratory technicians employed in commercial dental laboratories. The approximate ratios of auxiliaries to practicing dentists are as follows: assistants and secretary-receptionists, 1.2:1; hygienists, 1:8, and laboratory technicians, 1:3.5.

This survey also revealed that the number of full-time auxiliaries employed by dentists increased 27.7 per cent between 1962 and 1965 and that 7.3 per cent more self-employed dentists utilized the services of auxiliaries in 1965, as compared with 1962. These data indicate that the size of the auxiliary workforce is expanding rapidly and that the percentage of dentists using one or more of the three auxiliaries increased substantially during the three years since the last Association survey was made. In the same period it is significant to note that the number of self-employed dentists increased by only 2 per cent.

Current and Projected Educational Capacity: During the past decade, seven new dental schools have been established and the first-year enrollment capacity has increased by nearly 375 students. In the fall of 1966, the 49 dental schools in operation had a first-year capacity of 3,820. On the basis of dental school construction plans presently underway or announced, it is estimated that the freshman enrollment in dental schools will be increased to nearly 4,750 within the next five years. The following projections were prepared by the Council on Dental Education in the summer of 1966.

Projections of First-Year Capacity and Dental School Graduates: 1964-1975

Year	Number of Dental Schools	First-Year Capacity	Estimated Number of Graduates*
1964	49	3,836	3,213
1965	49	3,806	3,181
1966	49	3,820	3,210
1967	49	4,178	3,380
1968	52	4,459	3,494
1969	53	4,618	3,490
1970	53	4,697	3,503
1971	54	4,747	3,831
1972	54	(expansion	4,089
1973	54	information	4,235
1974	54	not available)	4,307
1975	54		4,353

*Figures for 1967 and beyond represent 91.7 per cent of the first-year class, four years earlier.

POPULATION STATISTICS

Estimates by Single Years of Age of the Total Population of the United States Including Armed Forces Overseas, by Color and Sex, July 1, 1965
(In thousands)

Age	All Classes			White			Nonwhite		
	Total	Male	Female	Total	Male	Female	Total	Male	Female
Under 1	3,857	1,969	1,888	3,219	1,647	1,572	639	322	316
1	4,049	2,068	1,981	3,386	1,733	1,653	663	334	328
2	4,094	2,091	2,004	3,440	1,761	1,679	654	330	325
3	4,170	2,128	2,041	3,513	1,798	1,715	657	331	326
4	4,265	2,176	2,088	3,604	1,844	1,759	661	332	329
5	4,134	2,101	2,032	3,517	1,795	1,722	617	307	310
6	4,137	2,100	2,037	3,531	1,797	1,733	606	303	304
7	4,127	2,098	2,029	3,536	1,802	1,734	591	296	295
8	4,113	2,089	2,023	3,523	1,795	1,728	590	294	295
9	4,008	2,038	1,971	3,434	1,750	1,683	575	288	287
10	3,987	2,028	1,959	3,420	1,745	1,676	567	283	283
11	3,889	1,974	1,915	3,344	1,702	1,642	545	272	273
12	3,815	1,938	1,877	3,288	1,674	1,614	528	264	264
13	3,678	1,871	1,807	3,181	1,623	1,558	497	248	249
14	3,587	1,823	1,763	3,090	1,575	1,515	496	248	248
15	3,490	1,775	1,715	3,012	1,536	1,476	478	239	238
16	3,518	1,787	1,732	3,052	1,553	1,499	466	233	233
17	3,523	1,791	1,732	3,079	1,569	1,511	444	223	221
18	3,741	1,898	1,843	3,318	1,687	1,631	423	211	212
Total	74,182	37,743	36,437	63,487	32,386	31,100	10,697	5,358	5,336

Source: U. S. Bureau of the Census, *Current Population Reports*, Series P-25, No. 321, "Estimates of the Population of the United States, by Age, Color, and Sex: July 1, 1960 to 1965," Table 4, page 23.

Population Projections by Single Year of Age—Series B
(In thousands)

	1970	1975	1980	1985
Under 1	4,168	5,006	5,696	6,129
1	4,031	4,871	5,592	6,070
2	3,940	4,743	5,487	6,010
3	3,880	4,612	5,378	5,950
4	3,809	4,482	5,257	5,874
Total	19,828	23,714	27,410	30,033
5	4,283	4,191	5,022	5,712
6	4,184	4,063	4,901	5,619
7	3,945	3,973	4,774	5,517
8	4,040	3,915	4,645	5,407
9	4,139	3,844	4,517	5,288
Total	20,591	19,986	23,859	27,543
10	4,165	4,314	4,222	5,053
11	4,169	4,215	4,094	4,930
12	4,156	3,974	4,003	4,803
13	4,142	4,069	3,945	4,673
14	4,039	4,169	3,873	4,544
Total	20,668	20,741	20,137	24,003
15	5,453	4,193	4,340	4,250
16	3,543	4,195	4,243	4,123
17	3,478	4,184	4,000	4,031
18	3,354	4,170	4,099	3,972
Total	15,828	16,742	16,682	16,376
Total	76,915	81,183	88,088	97,955

Based on data contained in the following: U.S. Bureau of the Census, *Current Population Reports*, Series P-25, Nos. 286 and 329, "Population Estimates."

DATA ON AUXILIARY UTILIZATION

Percentage of Nonsalaried Dentists Employing Specified Number and Type of Auxiliary Personnel in 1964

No. of Positions		Type of Personnel			
Full-Time Occupied All Year	Part-Time or Occupied Only Part of Year	Hygienists	Technicians	Assistants	Sercetaries and Receptionists
0	0	79.8	93.7	17.6	71.4
0	1	9.9	1.7	5.0	5.7
0	2	0.9	0.3	1.8	0.2
0	3	0.1	0.1	0.4	—
0	4	—	0.0	0.1	0.0
0	5	0.0	0.0	—	0.0
1	0	8.5	3.3	49.7	20.3
1	1	0.6	0.1	11.7	1.5
1	2	0.0	0.0	1.3	—
1	3	—	0.0	0.2	0.0
1	5	0.0	0.0	—	0.0
2	0	0.2	0.6	8.6	0.8
2	1	0.0	0.1	1.5	—
2	2	0.0	0.0	0.4	—
2	3	0.0	0.0	0.1	0.0
3	0	0.0	0.1	1.0	0.1
3	1	0.0	0.0	0.1	0.0
3	2	0.0	0.0	0.1	0.0
4	0	0.0	0.0	0.2	0.0
4	1	0.0	0.0	0.1	0.0
4	2	0.0	0.0	—	0.0
4	3	0.0	0.0	—	0.0
5	0	0.0	0.0	—	0.0
5	2	0.0	0.0	—	0.0
6 or more	0, 1 or more	0.0	—	0.1	0.0
Total		100.0	100.0	100.0	100.0

— Entry means less than 0.05 per cent.

Percentage of Nonsalaried Dentists Employing Specified Number and Type of Auxiliary Personnel in 1965

Type of Personnel	Full-Time			Part-Time		
	1	2	3 or more	1	2	3 or more
Hygienists	10.6	0.4	0.0	7.7	0.5	0.1
Technicians	3.2	0.6	0.1	1.1	0.1	—
Assistants	63.4	12.7	1.7	11.4	2.2	0.5
Secretaries and receptionists	22.9	0.6	0.1	4.4	0.2	—

-- Entry means less than 0.05 per cent.

Percentage of Nonsalaried Dentists Employing Auxiliary Personnel in 1965— According to Age of Dentist and by Type of Personnel

Age of Dentist	Type of Personnel							
	Hygienists		Technicians		Assistants		Secretaries and Receptionists	
	Full-Time	Part-Time Only	Full-Time	Part-Time Only	Full-Time	Part-Time Only	Full-Time	Part-Time Only
-29	4.3	4.3	0.9	0.9	81.0	3.4	12.1	6.0
30-39	11.2	9.6	3.8	1.8	94.4	2.2	30.4	4.0
40-49	13.3	9.4	3.8	1.4	81.7	3.4	25.4	4.6
50-59	12.4	6.1	5.4	0.5	69.4	1.4	20.6	2.5
60-69	8.3	3.6	5.0	0.0	61.4	3.0	16.2	2.6
70-	4.8	1.2	6.0	0.0	45.2	4.8	11.9	1.2
All ages	11.0	7.7	4.0	1.1	78.0	4.0	23.6	3.7

PERMISSIBLE OPERATIONS BY DENTAL HYGIENISTS*
Prepared by Council on Legislation, American Dental Association

*Legal for dental assistants when starred.

	Alabama	Alaska	Arizona	Arkansas	California	Colorado	Connecticut	Delaware	District of Columbia	Florida	Georgia	Hawaii	Idaho	Illinois	Indiana	Iowa	Kansas	Kentucky	Louisiana	Maine	Maryland	Massachusetts	Michigan	Minnesota	Mississippi	Missouri
1. OPERATIONS				no										*	(36)									(46)		
Administer anesthetics			(7)	(12)		(1)			(1)	(1)				x	x		(1)	x		(1)		x		x		
	*									*		*		*	*		*		*	*			*			
X-ray	x			x		x				x		x		x	x	x	x	x	x	x	x	x	x	x	x	
																						(44)				
Others	(2)		(8)				(17)	(8)		(24)	(28)				(35)					(38)	(9)	(2)		(52)		
																									(49)	
Apply topical medication					x	x		x		x		x	x	x	x	x		x		x	x	x		x	x	
		(5)										(5)														
Use mouthwash		x									x	x			x								x	x		
2. PLACE OF EMPLOYMENT																										
Under direction of Dentist	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Health Department		x	x						x	x		x			x	x	x			x			x		x	
														(34)												
School Authority			x		x	x		x	x			x	x	x	x	x			x		x	x	x	x	x	
		(3)										(29)									(41)					
Public Institution		x	x		x	x	x	x	x	x	x	x	x	x	x	x	x		x	x	x	x	x	x		
3. RESTRICTIONS																										
Female Hygienists only	x						x	x							x									x		
Maximum number of Hygienists per Dentist			1			1			(20) 2	(20) 2				2				2								1
License Needed to Practice Dental Hygiene	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Prohibitions against operations not specified in law	x	x	x		x	x	x	x	(12) x	x		(32) x		x	x	x	x		x	x		x	x	x		x

PERMISSIBLE OPERATIONS BY DENTAL HYGIENISTS*
Prepared by Council on Legislation, American Dental Association

*Legal for dental assistants when starred.

	Montana	Nebraska	Nevada	New Hampshire	New Jersey	New Mexico	New York	North Carolina	North Dakota	Ohio	Oklahoma	Oregon	Pennsylvania	Rhode Island	South Carolina	South Dakota	Tennessee	Texas	Utah	Vermont	Virginia	Washington	West Virginia	Wisconsin	Wyoming
1. OPERATIONS									(47)			(50)													
Administer anesthetics									x			x				x	(7)								
X-ray			* x		* x			x	x		x	(50) x	* x			x	x	* x			* x	* x	x		
Others									(8) (9)			(50) (51)			(27)	(8)	(19)		(8)		(2)				
Apply topical medication				(10) x			x		x	x	(33) x	(31) x	x			x	x	(15) x	(49) x	x	x	x	x		
Use mouthwash	x				(30) x				x													x		x	
2. PLACE OF EMPLOYMENT																									
						(48)			(45)																
Under direction of Dentist	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Health Department	x		x	x		x		x	x				x				x	x			x	x	x	x	
School Authority	x	x	x	x		x	x	x	x	x	x		x	x	x	x		x	x	x		x	x	x	
Public Institution	x	x	x	x	x	x	x	x	x	x		x	x	x	x	x		x		x	x	x	x	x	x
3. RESTRICTIONS																									
Female Hygienists only											x			x	x	x			x						
Maximum number of Hygienists per Dentist		1	2		1	1		1	1	1	2	1						(14) 1	1		1	1		1	
License Needed to Practice Dental Hygiene	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Prohibitions against operations not specified in law	x						x		x		x		x	x	x	x			x	x	x	x	x	x	x

PERMISSIBLE OPERATIONS BY DENTAL HYGIENISTS*
Prepared by Council on Legislation, American Dental Association

*Legal for dental assistants when starred.

	Alabama	Alaska	Arizona	Arkansas	California	Colorado	Connecticut	Delaware	District of Columbia	Florida	Georgia	Hawaii	Idaho	Illinois	Indiana	Iowa	Kansas	Kentucky	Louisiana	Maine	Maryland	Massachusetts	Michigan	Minnesota	Mississippi	Missouri
4. ANATOMICAL LIMITATIONS ON DENTAL HYGIENE PRACTICE																										
Teeth	x	x		x									x					x					x			x
Exposed surfaces of teeth	x		x			(23) x		x		(23) x	(26) x			x					x		(39) x			x	x	
Directly beneath free margins of gums						x	x			x					x	x	x	x		x		x				x
Others					(13)				(21)						(21)											
5. DENTAL HYGIENE PROPHYLACTIC PROCEDURES																										
Clean teeth		x										x	x		x			x						x		
Polish teeth	x												x		x			x		x	(40) x	(43) x		x		x
Remove accretions or concretions	x		x	x	x	x	x		x	x			x	x	x	x	x	(37) x	x	x	x	x	x	x	x	(37) x
Remove lime deposits			x	x	x	x										x	x			x	x	x		x		
Remove calcareous deposits	x					x	x	x	x	x	x				x			x	x	x	x	x	x		x	x
Remove stains	x		x	x	x	x	x	x	x	x	x		x	x		x	x		x	x	x	x	x	x	x	x
Others											(25)							x				(42)				

PERMISSIBLE OPERATIONS BY DENTAL HYGIENISTS*
Prepared by Council on Legislation, American Dental Association

*Legal for dental assistants when starred.

	Montana	Nebraska	Nevada	New Hampshire	New Jersey	New Mexico	New York	North Carolina	North Dakota	Ohio	Oklahoma	Oregon	Pennsylvania	Rhode Island	South Carolina	South Dakota	Tennessee	Texas	Utah	Vermont	Virginia	Washington	West Virginia	Wisconsin	Wyoming
4. ANATOMICAL LIMITATIONS ON DENTAL HYGIENE PRACTICE																									
Teeth		x		x		x		x																x	
Exposed surfaces of teeth					x		x	x				x		x		x	x	x			(6)	x	x		
Directly beneath free margins of gums	x		x			x		x	x	x	x		x		x					x					x
Others		(21)	(21)			(21)												(16)	(11)				(21)	(21)	
5. DENTAL HYGIENE PROPHYLACTIC PROCEDURES																									
Clean teeth				x					x			x							x						
Polish teeth		x	x			x		x	x			x				x	x	x	x		x				
Remove accretions or concretions	x	x	(37) x		x	(37) x	x	(37) x	x	x	x	x	x	x	x	x	x	x	x	x		x	x	x	x	x
Remove lime deposits		x					x		x		x	x		-		x		x		x			x		
Remove calcareous deposits	x		x		x	x	x	x	x	x		x		x	x		x	x	x		x	x	x	x	x
Remove stains	x	x	x		x	x	x	x	x	x	x	x	x	x	x	x	x	(18) x		x	x	x	x	x	x
Others													(42)					(42)							

Dental Auxiliary Footnotes

1. By a qualified anesthetist or registered nurse.
2. May assist a licensed dentist in his practice.
3. Any licensed dentist, legally incorporated eleemosynary dental dispensary or infirmary, private school or welfare center, the U.S.A. or the State of Alaska may employ licensed dental hygienists.
4. May perform only such operations as are cleansing.
5. The Board of Dental Examiners must approve the mouthwash used.
6. From the exposed surfaces of the teeth beginning at the epithelial attachment.
7. A qualified registered nurse anesthetist may administer an anesthetic.
8. Make a dental examination.
9. The charting of cavities.
10. Apply topically, fluorine, or any of its compounds and any other clinical compound or combination of, or a series of chemical compounds which may be found to be effective and approved by the New Hampshire State Dental Board.
11. From surfaces of human teeth outside of the line of normal attachment to the gum tissue but not beyond.
12. Specifically, a dental hygienist may not administer an anesthetic.
13. From the unattached surfaces of the teeth, this means the "portion of the crown and root surface to which there is no peridental membrane attached".
14. No dental office, regardless of the number of dentists, shall have more than two dental hygienists employed.
15. May make topical application of drugs to the surface tissues of the human mouth and to the exposed surfaces of the human teeth.
16. From the natural and restored surfaces of exposed human teeth and restorations thereof in the human mouth and the polishing of said surfaces.
17. May mark charts indicating defective teeth.
18. May remove stains "except mottled enamel stains".
19. May inspect and make notations of oral conditions.
20. May employ more than two with written permission of the board. The limitation does not apply to public institutions and Health Department.
21. From the surfaces of the teeth.
22. Shall not diagnose or treat any pathological conditions of the teeth or tissues of the mouth.
23. From the gingival sulcus.
24. May remove and insert temporary dressings and generally clear the area after work has been performed by the dentist.
25. Secretions.
26. "Normally" exposed surfaces of the teeth.
27. May polish to smoothness any overhanging margins or fillings or unevenness of the surface of the enamel.
28. Sterilization and office routine.
29. Any licensed dentist, eleemosynary dental dispensary, private school or welfare center, the Department of Public Instruction or the Board of Health may employ a hygienist.
30. Uses disclosing solutions.
31. Applies and uses within a patient's mouth such technical procedures, including the use of such drugs as may be approved by the American Dental Association and the State Board of Dental Examiners for the prevention of dental caries, under the direction of a licensed dentist.
32. Specifically, may not perform any repair work or the preparation thereof.
33. May give topical caries prevention treatment to the extra-coronal surfaces of the teeth.
34. A "public school" or a "public clinic".
35. "Removes rough and overhanging margins of fillings, makes instrumental examination of her patient's teeth, charts the results of such examination."
36. May assist in the administration of an anesthetic.
37. Removes accumulated accretion from directly beneath the margins of the gums.
38. May make oral examinations by mouth mirror and explore for the detection of cavities.
39. From the surfaces of the teeth and restorations.
40. And restorations.
41. May practice in an industrial clinic.

42. Tartar.
43. Polish teeth and fillings.
44. Record or report to a registered dentist any oral conditions observed.
45. Must operate under direct supervision of a dentist, except in a school or public institution may operate under general supervision.
46. May administer gas, ether and general anesthetic.
47. May assist in the administration of gas, ether and general anesthetic.
48. Apparently a dental hygienist practicing in a school or institution need not do so under the supervision of a dentist.
49. May apply such agents as the dentist may direct.
50. Only after Board issues appropriate regulations.
51. Use of drugs.

Supplemental Reports and Resolutions

Submitted by Councils, Constituent Societies and Other Agencies

COUNCIL ON DENTAL CARE PROGRAMS: SUPPLEMENTAL REPORT 1

Uniform Claim Form: The goal of a single claim form adaptable for use in all dental prepayment programs was achieved with the approval of a uniform form by the Council on Dental Care Programs and the Health Insurance Council. The Board of Directors of the National Association of Dental Service Plans has approved the basic form for recommended use by dental service corporations.

The new form is composed of a basic section with optional questions which can be deleted or altered to fit specific needs of carriers or coverage. The basic section plus optional questions provides uniformity but allows for adaptability by carriers.

In August the Council on Dental Care Programs distributed the uniform claim form to constituent society presidents, secretaries and executive secretaries and prepayment committee chairmen as well as to executives of dental service corporations and national specialty groups. The form was also described in the September, 1967, issue of *The Journal.*

The HIC will distribute the form to the health insurance industry along with instructions for its use. It is expected by the HIC and the Council that most companies will adapt this form for use in dental coverage. The Council on Dental Care Programs trusts that this form will replace any forms developed by constituent societies for interim use pending the approval of a uniform claim form at the national level.

RESOLUTIONS

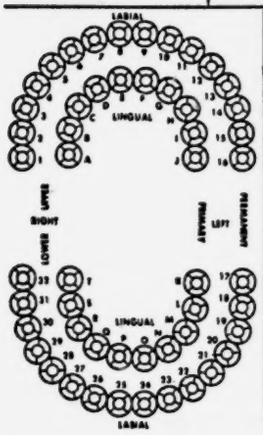
This report is informational in nature and no resolutions are presented.

APPENDIX
UNIFORM CLAIM FORM

ATTENDING DENTIST'S STATEMENT – INSURANCE CLAIM

(This space may be used in any way Carrier wishes. Could show: Carrier name and address - Policyholder name, etc.)

1. EMPLOYEE NAME	2. SOCIAL SECURITY NO.	3. NAME OF GROUP DENTAL PLAN	
4. EMPLOYEE MAILING ADDRESS		5. POLICY NUMBER 6. UNION LOCAL NO.	
7. CITY STATE ZIP		8. EMPLOYER NAME	*(This space may be used for instructions or in any other way Carrier wishes)*
9. PATIENT NAME	10. PATIENT RELATION SHIP TO EMPLOYEE	11. PATIENT BIRTHDATE MONTH / DAY / YEAR	12. DATE PATIENT FIRST VISIT (CURRENT SERIES)
13. DENTIST NAME 14. LICENSE NO.		15. IS PATIENT COVERED BY OTHER PLAN? (NAME OTHER PLAN)	YES / NO
16. DENTIST MAILING ADDRESS 17. PHONE NO.		18. IS ANY OF TREATMENT FOR * ORTHODONTIC PURPOSES?	
19. CITY STATE ZIP		20. TREATMENT RESULT OF ACCIDENT?	
		21. RESULT OF OCCUPATIONAL INJURY?	
22. IF PROSTHESIS, IS THIS INITIAL PLACEMENT? YES / NO (IF NO, REASON FOR REPLACEMENT)		23. DATE OF PRIOR PLACEMENT	24. ARE X-RAYS ENCLOSED? * (IF YES, HOW MANY)



* INDICATE MISSING TEETH WITH AN 'X'

26. REMARKS FOR UNUSUAL SERVICES

25. EXAMINATION AND TREATMENT RECORD-LIST IN ORDER FROM TOOTH NO. 1 THROUGH TOOTH NO. 32.

TOOTH # OR LETTER	SURFACES	DESCRIPTION OF SERVICE (INCLUDING X-RAYS, PROPHYLAXIS MATERIALS USED, ETC.)	DATE SERVICE PERFORMED MO DAY YR	PROCEDURE NUMBER	FEE	DO NOT USE THIS COLUMN

ORTHODONTICS *(give diagnosis, class of malocclusion and describe appliance(s) in above treatment section)*

DATE FIRST APPLIANCE INSERTED		TOTAL FEE ACTUALLY CHARGED
DATE LAST APPLIANCE REMOVED		* PATIENT PAYS
TREATMENT PERIOD *(Number months)*		* BALANCE
TOTAL FEE	$	* CARRIER %
		* CARRIER PAYS

* I HEREBY ACCEPT THE FOREGOING TREATMENT PLAN AND AUTHORIZE RELEASE OF ANY INFORMATION RELATING TO THIS CLAIM

PATIENT'S SIGNATURE _____ *(Or employee if patient is a minor)*

* I HEREBY CERTIFY THAT THE SERVICES LISTED ABOVE WILL BE OR HAVE BEEN PERFORMED.

DENTIST SIGNATURE _____ DATE _____

* I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE ABOVE-NAMED DENTIST OF THE GROUP INSURANCE BENEFITS OTHERWISE PAYABLE TO ME, BUT NOT TO EXCEED THE CHARGES SHOWN ABOVE. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ANY CHARGES NOT COVERED BY THIS AUTHORIZATION.

PATIENT'S SIGNATURE _____ DATE _____ *(Or employee if patient is a minor)*

* INDICATES OPTIONAL QUESTIONS

Approved by the Council on Dental Care Programs of the American Dental Association July 1967

COUNCIL ON DENTAL THERAPEUTICS: SUPPLEMENTAL REPORT 1

Change in Name of "Accepted Dental Remedies": At its meeting on June 15-16, the Council on Dental Therapeutics voted to recommend a change in the name of its principal publication from *Accepted Dental Remedies* to *Accepted Dental Therapeutics.* The Council noted that the term, "remedies", is archaic and is not presently an accurate reflection of the content of the book.

This recommendation involves an amendment of the *Bylaws,* Chapter XIV, Section 50 (p. 38).

The Council recommends approval of the appended resolution.

RESOLUTION

19. **Resolved,** that the *Bylaws,* Chapter XIV, Setion 50, "Accepted Dental Remedies", be amended by deletion of the word "Remedies" where it appears in two places and substituting therefor "Therapeutics".

COUNCIL ON LEGISLATION: SUPPLEMENTAL REPORT 1

Dental Services Under Title XVIII of Medicare Act: At its June 20-21 meeting, the Council met with representatives of the American Society of Oral Surgeons to discuss the dental benefits provided under Title XVIII (Medicare) of the Social Security Act. The Board of Trustees had requested the Council to review an ASOS recommendation that an effort be made to remove certain harsh limitations on Title XVIII dental benefits. The Council agreed to cooperate with the Society in an effort to remove several severe limitations on dental services imposed by the Social Security Administration guidelines for Part B dental services under Title XVIII. The Social Security Administration has interpreted the law to prohibit payment for any dental procedure which is performed in preparation for inserting a prosthetic appliance, including complicated surgery of the gingival or jaws. A meeting is scheduled for mid-September with Social Security Administration officials.

The Council also agreed to join the American Society of Oral Surgeons in recommending an amendment to Part A of Title XVIII to eliminate the harsh restrictions on payment for hospital costs when Title XVIII beneficiaries are admitted to a hospital for dental services. Under existing law the Social Security Administration will provide reimbursement of hospital costs involving dental patients only if (1) the dental procedure is specifically covered as a Part B benefit or (2) the patient has a medical condition that requires hospitalization for proper performance of the dental procedure. The Council agrees with the ASOS that a Title XVIII beneficiary who must be hospitalized for proper performance of a dental procedure should receive the hospitalization benefits provided by Part A. The Council submits an appropriate resolution at the end of this report.

Children's Dental Care Program (H.R. 12080): On August 17, the House of Representatives passed by a vote of 414 to 3 H.R. 12080, the "Social Security Amendments of 1967". Section 301 of H.R. 12080 contains the authority to initiate projects for the comprehensive dental care of children of school age or pre-school children. H.R. 12080 is a substitute for the Administration's bill, H.R. 5710. The children's dental provisions of the new bill are substantially similar to those in Section 302 of H.R. 5710, the old bill. In the report of the House Committee on Ways and Means, the Committee emphasizes that the projects must be "in areas with concentration of low-income families". In a section of the report devoted to discussion of dental health for children, the Committee specifically states that "Payment for treatment would be limited to children from low-income families". The only significant differences between the children's dental health provisions of H.R. 12080 and H.R. 5710 are: (1) The funds authorized for dental health projects in the new bill are lumped with funds for maternity and infant care and for comprehensive health care for school-age and pre-school children. If H.R. 12080 becomes law the dental project program could be allotted as much as $15 million for three years and $25 million for the fourth year. (2) Under the new bill the funds would become available on July 1, 1968 and would be available for projects through June 30, 1972. (3) After June 30, 1972, the funds authorized would be available to the states to continue on a permanent basis the programs previously supported on a project basis, including the children's dental care program. Instead of providing federal matching funds of 75 per cent of program costs as would be the case during the four project years, H.R. 12080 would provide, after June 30, 1972, that funds be appropriated to the states on a formula basis taking into account the number of children in each state and the financial need of each state.

The Council will testify before the Senate Finance Committee on H.R. 12080 in late August or early September.

New Promotion Plan for Armed Services Dental and Medical Officers (H.R. 10242): The Council was successful in its effort to include dental officers in the new promotion opportunity plan sponsored by the Department of Defense. The original version of H.R. 10242 limited the plan to medical officers. The House Committee on Armed Services, after receiving testimony on July 25 from Dr. I. Lawrence Kerr, vice-chairman of the Council, unanimously voted to include dental officers. The Council received exceptional support from the membership in this effort. The Senate Armed Services Committee is expected to act on H.R. 10242 in September.

Dental Care for Dependents of Uniformed Services Personnel: The special subcommittee on dental care of the House Armed Services Committee held hearings on July 24-25 to study the desirability of adding comprehensive dental care to the benefits provided under the military dependents care act. Dr. Kerr and Dr. F. Gene Dixon, chairman of the Council on Dental Care Programs, testified for the Association. Drs. Kerr and Dixon emphasized that if Congress decides to provide dental benefits to dependents, the care should be provided by dentists in private practice and payments to dentists should be on a usual and customary fee basis. The dental care subcommittee will undoubtedly recommend that any legislation to provide dependents dental care not be considered until 1968, during the second session of the 90th Congress.

Comprehensive Health Service and Planning (H.R. 6418): The House of Representatives passed H.R. 6418 in early August. The Council testified before the House Interstate and Foreign Commerce Committee on the legislation on June 20. Dr. John B. Wilson, chairman of the Council, urged the Committee to consider clarifying language in the bill to define more precisely the concept of "comprehensive health services". Dr. Wilson stressed that any responsible definition of "comprehensive health services" must include dental public health activities. The Committee did include language in its report on H.R. 6418 that should be helpful in identifying dental health as an important component in any state or local public health plan.

Appropriations for Public Health Service Dental Activities (H.R. 10196): The Senate added $2 million to the Administration's request for the National Institute of Dental Research budget. If the Senate version of H.R. 10196 prevails, NIDR will have $32 million for fiscal 1968. The additional $2 million is allotted for the development of regional institutes of dental research. The Division of Dental Health will receive $10 million for its fiscal 1968 activities.

Internal Revenue Service Hearings on Unrelated Income: The Council Secretary testified for the Association at hearings before the Internal Revenue Service on proposed regulations to tax advertising and exhibit income of tax-exempt organizations. The Association's testimony pointed out especially the educational value to the profession derived from journal advertising and annual session commercial exhibits.

Radiation Protection Bills: The Council has arranged to testify before the Senate Commerce Committee on S. 2067, the so-called Electronic Products Radiation bill, on August 30. The Council will emphasize both the necessity for dental x-rays as in diagnosis of dental disease and the safety features employed by dentists in the use of dental x-ray machines.

Dental Laboratory Licensure: The Council met with representatives of the National Association of Certified Dental Laboratories at the Council's June 20-21 meeting in Washington. The NACDL recommended that policy on state licensure of the dental laboratory industry and craft be left to the discretion of state dental associations and state dental laboratory associations. The Council described the reasons which establish a complete justification for the Association's position opposing licensure for the industry and craft and informed the NACDL representatives that nothing had been revealed to the council to warrant a change of Association policy on licensure for the dental laboratory industry and craft.

Statewide Fluoridation Legislation: Illinois has joined Connecticut and Minnesota in enacting statewide fluoridation requirements. On July 18, the Governor of Illinois signed into law a bill requiring the fluoridation of all municipal water supplies.

RESOLUTION

21. Resolved, that those provisions of Part A of Title XVIII of the Social Security Act which impose a limitation on payment of hospital costs for beneficiaries hos-

pitalized for dental care are unfair to the beneficiaries and are professionally unsound and, be it further

Resolved, that an amendment be sought to Part A of Title XVIII of the Social Security Act to authorize payment of hospital costs for beneficiaries who require hospitalization for a dental condition or affliction.

Minnesota State Dental Association

REQUEST FOR A CONFERENCE ON INSURANCE

The following resolution was adopted by the Board of Trustees of the Minnesota State Dental Association on July 29, 1967, and transmitted by Dr. Horace L. Drake, secretary, on August 1, 1967.

20. Whereas, many component and constituent societies, as well as other dental organizations, sponsor various group insurance plans, and

Whereas, an insurance conference is imperative to gain coordination and understanding in the many changes that have taken place in health and accident, major medical and retirement income insurance, and

Whereas, the last conference on insurance was held in the Headquarters Building of the American Dental Association in September, 1963, at which time it was voted by those in attendance that similar conferences should be held at periodic intervals, therefore, be it

Resolved, that a conference on insurance be held in the American Dental Association Headquarters Building during the year 1968.

Reports of Board of Trustees

To House of Delegates

REPORT 1 OF BOARD OF TRUSTEES TO HOUSE OF DELEGATES: ASSOCIATION AFFAIRS AND RESOLUTIONS

This is the first of a series of reports which the Board of Trustees will present to the House of Delegates at the annual session in Washington, D.C. In order to conserve the time of members of the House, the Board of Trustees has attempted to place related items in separate reports so that some will not require reading during the opening meeting.

Report 1: deals with Association affairs and administrative resolutions relating to such matters as nominations to councils and the election of life and honorary members.

Report 2: deals with the reports of councils and bureaus and their resolutions and with the resolutions presented by constituent societies and other agencies.

Report 3: deals with recommended amendments of the *Bylaws*.

Report 4: deals with increase of annual dues of active members.

Report 5: will be presented to the opening meeting of the House of Delegates and will deal with financial affairs and the recommended budget for the fiscal year 1968.

Appreciation to General Committee on Local Arrangements: The Association is pleased to return to the nation's capital for its annual session for the first time since 1951. In addition to its renown as one of the world's great capital cities, it is also the home of three distinguished Past Presidents of the Association. Dr. C. Willard Camalier, who is the oldest Past President in point of service, held office in 1937-38; Dr. Sterling V. Mead in 1946-47 and Dr. Daniel F. Lynch in 1954-55.

As visitors to the annual session will learn for themselves in the next few days—if they have not already learned it—the annual session events have been splendidly organized and present special features designed to reveal all of the attractions of this beautiful city. The Association is pleased to avail itself of the very generous hospitality of the District of Columbia Dental Society which serves as our host.

The entire annual session will bear the special mark of the personality of the genial, untiring and imaginative Chairman of the General Committee on Local Arrangements, Dr. Francis J. Fabrizio, more frequently identified as "Breezy". He has been ably assisted by Dr. Anthony P. Culotta as vice-chairman, by Dr. Albert G. Paulsen, as secretary-treasurer, by Mrs. M. Hazen Colvin, chairman of women's activities and by his other dedicated committee chairmen. This committee has been energetic in its organization, attentive to detail, warm in its hospitality and generous with its time and effort to provide the Association with an exceptional meeting.

The Board, on behalf of all members of the Association, expresses to Dr. Fabrizio and his committee the warmest thanks for their most successful efforts.

Death of Congressman John E. Fogarty: It is fitting that in this capital city, in which he labored so fruitfully for 14 terms in the House of Representatives, that the dental profession, through the Association, should have the opportunity to pay final tribute to Congressman John E. Fogarty who died suddenly on January 10.

Mr. Fogarty, who was an honorary member of this Association, was renowned in this country and abroad for his leadership and statesmanship in all fields of health. He shares with only a few others the credit for the magnificent advances which this nation has made in the past two decades in the field of health and health research. He was a vigorous advocate for many measures which have brought a higher level of health for many Americans. By the force of his great personality, his forthrightness, his impatience with delay, red tape and procrastination, by his knowledge and his courage he stimulated every level of government and millions of Americans to increased efforts to improve the nation's health.

His efforts in behalf of the dental profession and the services it renders to the public are many and unmeasured. His name is intimately associated with most of the advances which were made in the past decade through federal legislation. The Association is proud to acknowledge his great contributions to dentistry and his stature as a leader in public health whose memory will be enshrined in many hearts for generations to come.

Appointment of Treasurer: In accordance with the duty assigned by the *Bylaws,* the Board of Trustees has appointed Dr. Roger K. Trueblood as Treasurer of the Association for the three-year period ending December 31, 1970.

Encomium for Retiring Treasurer: The Board of Trustees wishes to acknowledge with great appreciation the services which Dr. E. Jeff Justis has rendered to the Association in the past three years during his term as Treasurer. He held this important office at a time when the Association confronted the many difficult problems of financing related to the construction of the new Headquarters Building. His experience, his sage counsel and his respect for sound, conservative fiscal management were of invaluable assistance during this period of Association expansion. The assured financial position of the Association is attributable, in significant part, to the com-

petence which Dr. Justis brought to the position of Treasurer. The Board of Trustees—and the members of the Association—are grateful to him.

Special Session of Board of Trustees: The Board of Trustees held a special session, following its regular spring session, on March 16-18 in the Headquarters Building. The special session was devoted to an extended review of various Association programs with a view to determining the trends and costs of future activities. The proceedings of the special session are reported in the current issue of *Reports of Officers and Councils,* pp. 189-207, and the Board believes many of the items discussed will be of interest to members of the House of Delegates since they forecast many matters which will require action in the near future.

Death of Past President C. Raymond Wells: The Board of Trustees notes with great regret the death on December 9, 1966 of Dr. C. Raymond Wells who served as President of the Association in 1943-1944. Dr. Wells served in the Naval Dental Corps with great distinction during the war years and achieved the rank of Rear Admiral. He was active in the Selective Service Program and contributed unstintingly to the Association even while on active service.

The Association extends its sincere condolences to members of the bereaved family.

Retirement of Dr. George C. Paffenbarger: After 38 years of service in the employ of the Association, Dr. George C. Paffenbarger has requested partial retirement at January 1, 1968. The Board acceded to his request with the knowledge that Dr. Paffenbarger would continue some of the activities in which he has won world renown but on his own schedule and on a part-time basis.

Dr. Paffenbarger was a pioneer in the field of dental materials and was the first full-time research investigator to join the staff of the Association. His personal achievements in the field of dental research and his leadership of the group of research workers who were eventually to join him at the National Bureau of Standards won for the Association a first place in the development of standards and specifications for dental materials. His unassuming competence, his generosity of time and effort in behalf of myriads of projects and his undeviating loyalty to the high ideals of his profession won for him the national and international recognition which he so richly deserves and carries with such genuine modesty.

The Board of Trustees, on behalf of the practitioners of dentistry everywhere, wishes to acknowledge with great appreciation the outstanding contributions which Dr. Paffenbarger has made to the Association, to dental research and to the dental profession.

Recognition of Employee Anniversaries: The Board of Trustees invites the members of the House of Delegates to join with it in expressing appreciation to three Association employees who are completing 30 years of service. Mr. Harold Caul is Assistant Director of the ADA Research Division at the National Bureau of Standards; Mrs. Catherine Lipke is supervisor of the Order Section and Miss Marian Luehring, supervisor of the Subscription Section, in the Headquarters Office. All have served the Association efficiently and loyally and richly merit the applause and recognition which 30 years of service have won for each of them.

Nominations to Councils: In accordance with Chapter VI, Section 90H of the *Bylaws,*

the Board of Trustees presents the following nominations for membership on the councils of the Association. Elections to councils will take place at the Wednesday meeting of the House of Delegates.

Nominations to Councils

Constitution and Bylaws, Council on
Voigt, Ott L., Texas, 1970

Dental Care Programs, Council on
Kramer, Harold M., Oregon, 1970
Lachnicht, Vitus J., New York, 1970

Dental Education, Council on
Hills, Dale A., Minnesota, 1970, ADA*
Lazarus, C. Hanford, New York, 1970, AADE**
Teuscher, George W., Illinois, 1970, AADS***

Dental Health, Council on
Trithart, Albert H., Tennessee, 1970

Dental Materials and Devices, Council on
Olsen, Jr., Edmund S., Minnesota, 1970

Dental Research, Council on
Howell, Charles L., Pennsylvania, 1970

Dental Therapeutics, Council on
Coy, Edward A., Ohio, 1970
McCarthy, Jr., Frank M., Southern California, 1970
Millard, Herbert D., Michigan, 1970

Dental Trade and Laboratory Relations, Council on
Brophy, Joseph T., Illinois, 1970

Federal Dental Services, Council on
Colvin, Jr., Ernest M., Washington, D.C., 1970

Hospital Dental Service, Council on
Pfister, Jack H., North Dakota, 1970

Insurance, Council on
Nickels, Clabourne, Arkansas, 1970

International Relations, Council on
Humphrey, William P., Colorado, 1970

Journalism, Council on
Seyler, Alfred E., Michigan, 1970

Judicial Council
Allen, Newton E., Alabama, 1970
Smith, Elbert H., California, 1969

Legislation, Council on
Rovelstad, Homer D., North Dakota, 1970

National Board of Dental Examiners, Council of
Allen, William H., Tennessee, 1970 AADS***
Hamm, George A., New York, 1970, AADE**
Ito, Allen M., Hawaii, 1970, ADA*

Relief, Council on
Skaalen, Lloyd O., Wisconsin, 1970

Scientific Session, Council on
Rader, C. Warren, West Virginia, 1970

*American Dental Association
**American Association of Dental Examiners
***American Association of Dental Schools

The Board of Trustees wishes to acknowledge with appreciation the years of service of the following council members who complete their terms with this annual session: Dr. H. Arthur Zappe, Council on Constitution and Bylaws; Dr. R. Quentin Royer, Council on Dental Education; Dr. Edward B. Gernert, Council on Dental Health; Dr. W. Arthur George, Council on Dental Research; Dr. James R. Hayward, Council on Dental Therapeutics; Dr. Harold J. Holt, Council on Dental Therapeutics;

Dr. George H. Fitz, Council on Dental Trade and Laboratory Relations; Dr. Richard D. Hardin, Council on Insurance; Dr. Taylor T. Hicks, Council of National Board of Dental Examiners; Dr. Thomas R. Abbott, Council on Relief; Dr. Clarence C. Cottrill, Council on Scientific Session.

100. Resolved, that the nominees for membership on the councils of the Association, submitted by the Board of Trustees in accordance with Chapter VI, Section 90H of the *Bylaws,* be elected.

Nominations for Life Membership: In accordance with Chapter VI, Section 90M of the *Bylaws,* the Board nominates for life membership 1,063 members from the following constituent societies and federal dental services. Upon their election, the Association will have 9,497 life members.

Life Membership Applicants by Constituent Society and Federal Dental Service

Alabama	2	Montana	4
Alaska	1	Navy	3
Arizona	2	Nebraska	10
Arkansas	4	New Hampshire	5
Army	3	New Jersey	50
California	53	New Mexico	4
California, Southern	42	New York	106
Colorado	7	North Carolina	7
Connecticut	6	North Dakota	9
Delaware	2	Ohio	79
District of Columbia	11	Oklahoma	10
Florida	28	Oregon	12
Georgia	7	Pennsylvania	121
Hawaii	6	Puerto Rico	2
Idaho	3	Rhode Island	5
Illinois	74	South Carolina	1
Indiana	23	South Dakota	2
Iowa	17	Tennessee	15
Kansas	13	Texas	28
Kentucky	12	Utah	3
Louisiana	10	Vermont	2
Maine	3	Veterans Administration	9
Maryland	10	Virginia	30
Massachusetts	41	Washington	11
Michigan	57	West Virginia	7
Minnesota	36	Wisconsin	36
Mississippi	2		
Missouri	17	Total	1,063

101. Resolved, that the 1,063 members nominated by the Board of Trustees in accordance with Chapter VI, Section 90M of the *Bylaws* be classified as life members.

American Dental Association-American Fund For Dental Education Student Loan Fund: The Association has contributed a total of $250,000 to the American Fund for Dental Education in support of the ADA-AFDE Student Loan Fund. Of this amount $239,420.50 has been prorated among the 48 dental schools participating in the program on the basis of student enrollment.

Through June 30, 1967, 1,383 students had received loans totalling $244,784. Of this amount $120,941 had been repaid. The remaining balance available for loan was $74,768.

It is also interesting to note that the participating schools reported that 6,447 dental students borrowed $8,417,222 from all sources during the past year.

Members of the Association have reason to be proud of their substantial contribution to support young men and women who are being educated for the dental profession.

Frequency of Issue of "Journal of Oral Surgery": The Board of Trustees has authorized the publication of the *Journal of Oral Surgery* on a monthly basis as of January 1, 1968 and an increase in the subscription price of this publication from $10 to $15 annually. The Board invites all members to place their subscriptions for this important and valuable Association publication.

Amendment of Rules of American Dental Association Relief Fund: The Board of Trustees wishes to advise the House that it has approved of the following amendment of the rules of the Relief Fund in regard to the distribution of contributions to the annual Relief Fund campaign:

> **Distribution of Contributions.** Three-fourths (¾) of the sum collected from members of a constituent society in the annual relief fund campaign will be returned to the relief fund of such constituent society. Provided, however, that, after July 1, 1965 such refunds may be made only to constituent society relief funds that have been established as charitable organizations having purposes consistent with the purpose of the American Dental Association Relief Fund and that have been accorded tax-exempt status under the Internal Revenue Code.
>
> For the period ending June 30, 1968, a constituent society will be paid a bonus of one-quarter (¼) of the total amount contributed by members of a constituent society in the annual relief fund campaign, provided that the constituent society (1) attains the annual quota assigned to it for the previous year by the Council on Relief, and (2) pays out in grants the previous year a sum greater than was received as a regular refund.

The Board of Trustees urges every constituent society to comply with the provisions of this amendment in order to receive the additional support available from the American Dental Association Relief Fund.

Establishment of Two New Departments: In order to focus additional attention on two important areas of the Association's program, the Board has authorized the establishment of two new departments in the Office of the Secretary of the Association: the Department of Constituent Society Services and the Department of Membership Development.

The Department of Constituent Society Services will coordinate efforts to improve communications and services to the constituent societies and their components.

The Department of Membership Development will develop and maintain programs for membership development, particularly among dental students. The Department

will also give attention to the development of dental student organizations in each of the dental schools.

As experience dictates, the Board of Trustees, at a later date, may wish to establish these agencies as bureaus of the Association by amendment of the *Bylaws*.

Bequest to American Dental Association Relief Fund: The Board of Trustees, on behalf of the Trustees of the Relief Fund, wishes to acknowledge with appreciation the bequest of $4,049.50 made by Mrs. Daisy J. Hall, widow of Dr. Rupert J. Hall, Illinois and Texas.

Progress in Civil Rights: The Board of Trustees wishes to congratulate the constituent and component societies for their whole-hearted cooperation in eliminating discriminatory barriers on entrance into Association membership. As of August 18, 1967 only four of the 467 component societies had not replied to the civil rights questionnaire. Only 21 of the questionnaires of the responding component societies are incomplete since they failed to indicate when there would be an opportunity to amend their bylaws to conform to the membership admission requirements established by the 1965 House of Delegates.

The Board of Trustees urges that this effort to remove all discriminatory barriers to entrance into membership be continued.

Tax Qualified Group Retirement Program for Members: The Board of Trustees is pleased to announce that, on the recommendation of the Council on Insurance, it has approved a tax qualified group retirement program for members of the Association.

The Board's decision and the Council's recommendation were based substantially on the actions of the Congress in 1966 which substantially increased the benefits under the Keogh Act. In summary, the amendments provide that, effective January 1, 1968, a deduction for the entire contribution under the plan (but not more than the lesser of $2,500 or 10 per cent of net earned income) will be permitted where previously the deduction was limited to 50 per cent of the contribution.

The program approved by the Board of Trustees will be underwritten by The Equitable Life Assurance Society of the United States which will provide the following benefits: the participant can select a fixed or variable investment program; there is no front- or rear-end load; the administration will be by the company so only the Association and the company will be involved; the trustees will be free to select another insurance company for the purchase of annuities if the rates of Equitable should become non-competitive; the promotion of the program will be in keeping with policies of the Association; quarterly reports will be made to participants indicating the value of their participation in the program; at retirement, the participant will have attractive alternatives for the withdrawal of funds in the purchase of fixed or variable annuities.

The program will become effective at January 1, 1968 and the Board of Trustees hopes that many members will avail themselves immediately of this additional benefit of Association membership.

United Nations Children's Fund (UNICEF): The United Nations Children's Fund (UNICEF) will mark its 21st anniversary on December 11, 1967. The Association

has been invited to join with other important national organizations in a salute to UNICEF through the adoption of a resolution pledging continued support to the work of the Children's Fund.

UNICEF was established on December 11, 1946 by the United Nations General Assembly through a resolution which grew out of a recommendation by the late President Herbert Hoover who had been asked by President Truman to survey the problem of hunger in the world and to make suggestions. UNICEF assists suffering children and mothers through the provision of vaccines, medicines, vitamins, jeeps, food, clinical equipment, supplies and consulting services. It is supported financially through voluntary contributions from governments and private sources in 120 nations.

In view of the traditional interest of the dental profession and of the Association in the health of all children, the Board presents the following resolution for the consideration of the House of Delegates.

> 102. **Resolved,** that the American Dental Association salute the United Nations Children's Fund (UNICEF) on the occasion of its 21st anniversary, December 11, 1967 and be it further
> **Resolved,** that commendation be offered for the immeasurable contribution of the Children's Fund to improving the health of millions of suffering children throughout the world, and be it further
> **Resolved,** that members of the Association be urged to support the program of the Children's Fund which is devoted primarily to an age group whose health is a primary concern of the dental profession.

Conference on Dental Laboratory Relations and Relations with NACDL: The 1966 House of Delegates requested the Board of Trustees "to provide funds to defray the expenses of one representative from each constituent society to a conference to be held early in 1967 to discuss the relations of the dental profession with the dental laboratory craft at local, state and national levels" (*Trans.* 1966:349).

This Conference was held on February 1-2, 1967 with one or more representatives from 53 of the 54 constituent societies. The theme of the Conference was the establishment of effective relations with the dental laboratory industry and craft at all levels. Major items on the Conference agenda were: the program of the Joint Commission on Accreditation of Dental Laboratories; the disruption of relations with the National Association of Certified Dental Laboratories and the National Board for Certification of Dental Laboratory Technicians; the proposal to establish a Registry for Dental Laboratory Technicians; state legislation leading to the licensure of dental laboratory technicians and dental laboratories; law enforcement; strengthening of relations at all levels with the Dental Laboratory Owners Association, a new national organization of dental laboratories, and the development of more effective profession-craft relations at state and local levels.

The Association's investment of approximately $20,000 in the Conference was a sound one, judged on the basis of the very active participation in the Conference discussions and in the subsequent acceleration of program activities at state and local levels to improve relations between the profession and the industry and craft.

The Board of Trustees also wishes to report that general discussions have been opened with officials of the National Association of Certified Dental Laboratories. Officials of the two associations met in Chicago on April 15 and agreed that agencies

of the two associations would meet to discuss three major issues: the program of the Joint Commission on Accreditation of Dental Laboratories; the future of the National Board for Certification of Dental Laboratory Technicians and legislation leading to the licensure or registration of dental laboratories and dental laboratory technicians. These three meetings have now been held. Representatives of NACDL have agreed to request their association to give consideration to support of the program of the Joint Commission but have indicated that a decision might not be reached prior to late 1968. In consultation with representatives of the Association's Council on Dental Education, representatives of NACDL's National Certifying Board have agreed to present to their government body certain changes which would make it acceptable to the Council on Dental Education. In consultation with the Council on Legislation, no joint position could be determined in regard to legislation for the licensing or registration of dental laboratories and dental laboratory technicians.

The Association is conducting these discussions in good faith but there is no reason for undue optimism that existing problems have been resolved. Until a decision is reached or until discussions are abrogated, the Association will continue its full support of the program of the Joint Commission, will develop plans for the initiation of the Registry for Dental Laboratory Technicians and will continue to oppose state legislation leading to the licensure or registration of dental laboratories and dental laboratory technicians.

The Board of Trustees urges the constituent and component societies to continue and enlarge programs of information to their members on dental laboratory relations.

REPORT 2 OF BOARD OF TRUSTEES TO HOUSE OF DELEGATES: RECOMMENDATIONS ON REPORTS OF COUNCILS AND RESOLUTIONS

The following are the comments and recommendations of the Board of Trustees on resolutions and reports which will be considered by the House of Delegates.

Constitution and Bylaws, Council on: The Board of Trustees recommends approval of Resolution 1.

Dental Care Programs, Council on: The Board of Trustees recommends approval of Resolutions 2 and 3.

Dental Education, Council on: The Board of Trustees is in agreement with the intent of the *Statement on Dental and Dental Hygiene Licensure* (Resolution 4). However, the Board wishes to call the attention of the House of Delegates to certain portions of the *Statement* that could be misinterpreted from the original intent of the *Statement,* and recommends the following amendments of the statement of principles:

In Item 1, delete the final sentence which reads as follows:

It is suggested, for example, that consideration be given to the evaluation of the candidate's credentials and professional background as an acceptable equivalent to examination.

In Item 3, third line, insert the word "individual" after "of" and before "state", the amended sentence to read:

The utilization of simultaneous or regional clinical examinations might be considered in lieu of individual state examinations.

In Item 4, first line, change the language to read:

State boards of dentistry, in consultation with constituent dental societies . . .

the amended sentence to read:

State boards of dentistry, in consultation with constituent dental societies, should take immediate and aggressive steps to develop mechanisms to insure the continued competence of all dentists licensed in their jurisdiction.

The Board of Trustees recommends the amendment of Resolution 4 by the insertion of the words "as amended", the amended resolution to read as follows:

Resolved, that the *Statement on Dental and Dental Hygiene Licensure,* as amended, be approved.

The Board of Trustees recommends the approval of Resolution 4 as amended.
The Board of Trustees recommends the approval of Resolutions 5 and 6.

Dental Health, Council on: The Board recommends approval of Resolutions 7 and 8.

Dental Research, Council on: The Board recommends approval of Resolution 9 and calls attention to its statement on the contributions of the late Congressman John E. Fogarty in Report 1 of the Board of Trustees to the House of Delegates.

Dental Therapeutics, Council on: The Board recommends approval of Resolution 19 in the supplemental report of the Council.

Federal Dental Services, Council on: The Board recommends approval of Resolution 10.

Hospital Dental Service, Council on: The Board recommends approval of Resolution 11.

Judicial Council: The Board of Trustees recommends approval of Resolution 12 with the addition of the following resolving clause to effect a further technical amendment of the *Bylaws*:

and be it further
Resolved, that Chapter V, House of Delegates, Section 40, Duties, item F of the *Bylaws* be amended by deleting the period at the end of the last sentence in the section and adding the following clause to item F:

except those decisions involving discipline of members.

to make the amended Section 40 read as follows:

Section 40. Duties: It shall be the duty of the House of Delegates:

A. To elect the elective officers.
B. To elect the members of the Board of Trustees.
C. To elect the members of councils.
D. To revise and act upon reports of the committees of the House of Delegates.
E. To adopt an annual budget.
F. To serve as the court of appeal from decisions of the Judicial Council except those decisions involving discipline of members.

The Board recommends approval of Resolution 12 as amended.

Legislation, Council on: The Board recommends approval of Resolution 21 in the supplemental report of the Council.

Joint Report of Councils on Dental Education, Dental Health and Legislation: Training and Utilization of Dental Hygienists and Dental Assistants: The Board of Trustees has reviewed the Joint Report with great interest and attention. The Board believes that when its recommendations are fully implemented by all of the states, this will become one of the landmark statements of the Association in devising constructive programs to meet the dental health needs of the American people. The Board believes that the Joint Report is an effective and constructive reply to any proposal for a system of federal licensure in the health professions.

The Board of Trustees believes that the approval and immediate implementation of the recommendations of the Joint Report will indicate the Association's continuing support for developing the American Dental Association Dental Health Program for Children which the House of Delegates approved in 1966 (*Trans.* 1966:306) on a continuing basis.

The Board of Trustees had some concern that the section of the Joint Report relating to "qualified" dental hygienists and dental assistants might be subject to misinterpretation. Since the Board believes that any delegation of duties to auxiliary personnel should be on the basis of their qualifications, the Board of Trustees proposes to amend Resolution 22 by an explicit definition of educational standards for the dental hygienist and dental assistant. The proposed amendment relates the "qualifications" of the dental hygienist and dental assistant directly to "educational standards approved by the American Dental Association" and to "practices acceptable to the constituent and component societies of the state until Association educational standards can be fully implemented".

The Board of Trustees points out that even with the approval of the Joint Report, the full responsibility for putting the recommendations into effect will rest with the individual states since there can be no delegation of duties in any state without appropriate recognition of such delegation in the individual dental practice acts.

The Board of Trustees strongly recommends that Resolution 22 be amended to read as follows:

> **Resolved,** that constituent societies be urged to consult immediately with their state boards of dental examiners, state officials, legislatures and other involved agencies to remove restrictions in the state dental practice acts which impair the right of the practicing dentist to exercise his professional competence and

judgment in the direction of the dental auxiliaries who work under his direct supervision, and be it further

Resolved, that such revision of the state dental practice acts include the elimination of the serial list of operations which may be carried out by the dental hygienist and dental assistant, and be it further

Resolved, that such revisions of the state dental practice acts include provisions which recognize the dentist's competence and responsibility in determining how dental auxiliary personnel qualified under educational standards approved by the American Dental Association or under practices acceptable to the constituent and component societies of the state until Association educational standards can be fully implemented, can be utilized to carry out duties which do not require the professional judgment or competence of the dentist.

The Board of Trustees recommends the adoption of Resolution 22 as amended.

Southern California Resolution on Closed Panel System of Dental Practice: This resolution attempts to establish at the national level a control on a form of dental practice when, by long-standing tradition, this control should be vested in the individual states. The Board believes that the more moderate and realistic statement of the House of Delegates in 1961 (*Trans.* 1961:253) accurately reflects Association policy in this area. The Board of Trustees does not believe that the complex problems relating to closed panels in the various states should be transferred to the American Dental Association in an effort to solve a particular problem which confronts a constituent dental society.

The resolution is also logically defective in that it expresses absolute opposition to closed panels, yet would countenance their establishment "under special circumstances".

The Board recommends that Resolution 13 be rejected.

Colorado Resolution on Changes in Requirements for Life Membership: The Board of Trustees does not believe that the implementation of the life membership requirements enacted by the House of Delegates last year should be delayed. Until 1961, every member who did not pay dues during the depression years, 1932-1935, could have established a serial record of dues payment by paying his arrears. This provided a period of almost 30 years for the payment of dues for the years that had been missed and the Board of Trustees sees no valid reason why this period should now be extended.

The Board recommends that Resolution 14 be postponed indefinitely.

Iowa Resolution on Amendment of Section 4 of the "Principles of Ethics": The Board of Trustees is in agreement with the intent of Resolution 15 that every encouragement should be made to have the dentist become a leader in the community and to support all programs of a progressive nature, not only dental programs. However, the Board wishes to call attention to Chapter IX, Section 110R, of the *Bylaws* which assigns the following duty to the Judicial Council:

a. To consider proposals for amending the *Principles of Ethics.*

Accordingly, the Board of Trustees has referred Resolution 15 to the Judicial Coun-

cil for study and report to the Board and to the House of Delegates at the 1967 annual session in Washington, D.C.

Iowa Resolution on Policy on Use of Association Films: The Board of Trustees has been advised of the facts in the matter which is the subject of Iowa Resolution 16 and is in agreement with the involved agencies that the denial of the request was proper and that Association policy should not be changed in regard to the distribution of films of this type.

In 1964, an advertising department of an Iowa television station approached a component society in that state in order to establish an advertising program. Both agencies then requested ADA public service films to be shown on TV time purchased by the component society. This request was denied by the Bureau of Public Information after consultation with the Directors of the Bureaus of Audiovisual Service and Dental Health Education.

The basic problem involved the desire of the component society to use ADA films on commercial TV time in face of the fact that the ADA films are produced for use on public service, or free, time. If the request of the component society had been granted, it is likely that component societies throughout the country would be approached by television officials to purchase time for dental health education messages to the public. If permission were granted to permit use of ADA films to one station for showing on paid time, there is no question but that other stations would seek the same source of revenue. The net result would be to convert some part of the present free time to paid time at the expense of dental health education messages to the public and of the component society.

The Board is advised that if the 11 films distributed last year by the Bureau of Audiovisual Service had been shown on paid time, the cost would be approximately $100,000. If the one-minute TV spots, sent to 260 TV stations last year were used on paid time, the cost would be approximately $2,500,000.

For these reasons, the Board recommends that Resolution 16 be rejected.

Maryland Resolution on Structure of Fourth Trustee District: At its 1966 session, the House of Delegates recommitted the following resolution to the Board of Trustees for study and report at the 1967 session (*Trans.* 1966:357):

> **Resolved,** that the Fourth Trustee District of the American Dental Association be composed of the federal dental services, District of Columbia, Maryland, Puerto Rico and the Panama Canal Zone, and be it further
> **Resolved,** that the New Jersey State Dental Society and the Delaware State Dental Association be made a separate district.

A review of the record of the House of Delegates on the composition of Trustee District 4 at the 1966 annual session (*Trans.* 1966:354) reveals that the Reference Committee presented a proposal identical with that contained in the recommitted Maryland resolution. The record shows further that the proposal was defeated by the House of Delegates by a vote of 170 to 68.

In view of the strong position taken by the House of Delegates on this proposal in 1966, the Board of Trustees believes no useful purpose will be served by its reconsideration.

The Board recommends that the Maryland resolution (1966 House Resolution 220) be rejected.

Minnesota Resolution Requesting Conference on Insurance: The Board of Trustees is in agreement with the objective of this resolution since good values would accrue to the constituent and component societies in the development of sound insurance programs for dentists. Since the resolution indirectly involves the appropriation of funds for the conference, the Board requests that the resolution be committed to the Board of Trustees for appropriate consideration and funding.

The Board recommends that Resolution 20 be committed to the Board of Trustees for appropriate consideration and funding.

New York Resolution on Listing in Character of Practice Section of "American Dental Directory": If approved, Resolution 17 would permit the listing of dentists in the "Character of Practice" section of the *American Dental Directory* who were merely certified by their component societies and do not limit their practices and have not met existing educational requirements for announcing limitation of their practices. The announcement of limitation of practice by a dentist who is not limiting his practice "exclusively to one of the special areas approved by the American Dental Association" is contrary to Section 18 of the *Principles of Ethics.* The New York resolution, therefore, proposes to repeal or modify one of the *Principles of Ethics* without directly addressing itself to the amendment of that document.

The Board of Trustees is aware of certain problems which confront the constituent society in establishing fees for the payment of specialists under the state Medicaid program. The Board believes that this problem should be solved at the level of the constituent society and not at the national level.

The Board recommends that Resolution 17 be rejected.

New York Resolution on Extension of Moratorium on New Special Areas of Dental Practice: At its 1966 session, the House of Delegates referred the following resolution to the Council on Dental Education for study and report at the 1967 annual session (*Trans.* 1966:344):

> **Resolved,** that the moratorium on new special areas of dental practice be extended for another period of three years.

The Board of Trustees is in agreement with the comment of the Council on Dental Education that "the House of Delegates has the final responsibility for acting on applications for the recognition of additional areas of special practice and the Council does not believe that dental groups representing special areas of interest should be denied the right of application, review and judgment by the House of Delegates through the means of a moratorium" (*Reports*:26).

The Board recommends that the New York resolution (1966 House Resolution 247) be rejected.

North Carolina Resolution on Labeling Shelf Life of Dental Materials: The Board of Trustees is advised that some drugs which have a limited shelf life are already required by regulation to carry an expiration date. All drugs are now required to bear a lot number from which it is possible to determine the date of manufacture.

In its evaluation of drugs and therapeutic products used by dentists, the Council on Dental Therapeutics reviews the problems of stability and as a provision of acceptance may require that the product container bear the date of manufacture or an expiration date; or the Council may review the method of distribution to insure that fresh products reach the consumer. The specification and certification program for dental materials, as administered by the Council on Dental Materials and Devices also includes a provision for dating materials that may deteriorate on standing.

It is apparent, therefore, that a mechanism already exists for accomplishing the intended purpose of the North Carolina resolution. The Board of Trustees recommends that Resolution 18 be postponed indefinitely.

1966 Resolution of Delegate Lentchner, The Dental Society of the State of New York, Committed to Board of Trustees: The 1966 House of Delegates referred to the Board of Trustees for study and report at the 1967 annual session the following resolution presented by Delegate Emil W. Lentchner, The Dental Society of the State of New York (*Trans.* 1966:330):

> **Resolved,** that the House of Delegates request that the Board of Trustees shall establish an Appeal Board to which any dentist will have the right of appeal when refused membership by a component or constituent society on a discriminatory or arbitrary basis. Judicial determinations of the Appeal Board shall be reported to the Board of Trustees. The Board of Trustees upon review of the actions of the Appeal Board shall make recommendations to the next session of the House of Delegates as to measures which may be applied under the *Bylaws* of the Association.

Elsewhere in its reports to the House of Delegates, the Board of Trustees indicates that all but four of the Association's 467 component societies have responded to the questionnaire dealing with discriminatory barriers which might affect a dentist's entrance into membership in the Association. In view of this result, the Board of Trustees does not believe that there is a pressing need at this time to disturb the normal channels to active membership by resorting to an extraordinary measure such as the establishment of an Appeal Board. The Board recommends that Resolution 230 of the 1966 House of Delegates be rejected.

REPORT 3 OF BOARD OF TRUSTEES TO HOUSE OF DELEGATES: RECOMMENDED AMENDMENTS OF *BYLAWS*

In order to conserve time, the Board of Trustees presents Report 3 which will not be read. The items in the report will be considered by the reference committees so all interested parties will have an opportunity to express their views on the questions presented.

Charter for Constituent Society in Virgin Islands—Amendment of "Bylaws": Under date of January 11, 1967, Dr. John Rueckl, 227 Golden Rock, Christiansted, St.

Croix, Virgin Islands petitioned for the establishment of a constituent society in the Virgin Islands. This petition was supported by 16 additional dentists practicing in the Virgin Islands. The petition cited that the dentists "are English speaking", that the Virgin Islands enjoy territorial status in the structure of the United States of America and that there is a need in the area "to advance dental education and research related to local needs and problems".

Status of Virgin Islands: The Virgin Islands, with an estimated population (1965) of 43,300, form part of the chain of islands separating the Caribbean and Atlantic Oceans. They were purchased from Denmark in 1917. Since 1927, the inhabitants have been citizens of the United States but do not vote in U.S. elections. The Islands are administered by the Department of the Interior and the governor is appointed by the President of the United States.

Provisions of ADA "Bylaws": The *Bylaws* of the American Dental Association provide (Chapter II, Section 10) that "a constituent society may be organized and chartered, subject to the approval of the House of Delegates, upon the application of at least twenty-five (25) dentists practicing in any state, territory, the District of Columbia, dependency or federal dental service of the United States, who are active or life members, in good standing, of this Association . . .".

Consideration by Board of Trustees: At its spring, 1967 session, the Board of Trustees considered the application from dentists in the Virgin Islands for constituent society status and noted (1) that the requirement of the *Bylaws* for 25 petitioners was not fulfilled and that (2) the requirement that the petitioners be active or life members of the Association also was not fulfilled. The Secretary has been advised that there are less than 25 dentists practicing in the Virgin Islands. Of the 17 petitioners, ten presently hold direct membership in the American Dental Association.

On the ground that the Board of Trustees wished to facilitate consideration of the petition of the dentists of the Virgin Islands for constituent society status, the following amendments of the *Bylaws* have been prepared for consideration of the House of Delegates at the 1967 annual session. The resolutions propose amendment of the *Bylaws* (1) to remove the requirement that 25 dentists must petition for the chartering of a new constituent society; (2) to remove the requirement that the petitioners must be active or life members of this Association and (3) to establish a constituent society in the Virgin Islands by the issuance of a charter.

103. Resolved, that Chapter II, Constituent Societies, Section 10, Organization, of the *Bylaws* be amended by deletion of the words and number "twenty-five (25)" and inserting in lieu thereof the word and number "fifteen (15)" and by deleting the words "who are active or life members, in good standing, of this Association". to make the amended section read as follows:

Section 10. Organization. A constituent society may be organized and chartered, subject to the approval of the House of Delegates, upon the application of at least fifteen (15) dentists, practicing in any state, territory, the District of Columbia, dependency or federal dental service of the United States. No such society shall be chartered in any state, territory,

the District of Columbia, dependency or federal dental service of the United States in which a constituent society is already chartered by this Association.

104. Resolved, that the Virgin Islands Dental Association be chartered as a constituent society of the American Dental Association on the date of the enactment of this resolution, _____, 1967.

105. Resolved, that Chapter II, Constituent Societies, Section 110, Chartered Constituent Societies, of the *Bylaws* be amended by inserting in the appropriate alphabetic place in the listing of the chartered constituent societies the name "Virgin Islands Dental Association" and be it further

Resolved, that Chapter IV, Trustee Districts. Section 30, Composition, of the *Bylaws* be amended by inserting in the appropriate alphabetic place under District 4 the name "Virgin Islands Dental Association".

Elimination of Council on Constitution and Bylaws—Amendment of "Bylaws": From time to time in recent years, the Board of Trustees has reviewed the necessity for the continuation of the Council on Constitution and Bylaws. The Council meets only during an annual session of the Association to review the amendments to the *Bylaws* presented by other agencies of the Association. While the budget of this Council is nominal, $1,685 for 1967, the Board of Trustees does not believe continuance of this agency is warranted since the technical wording of amendments is largely an administrative problem.

The Board requests the House of Delegates to consider amendment of the *Bylaws* to eliminate the Council on Constitution and Bylaws. If the necessity for broad revision of the *Constitution and Bylaws* should arise at some time in the future, the Board will request the appointment of a special committee for this purpose.

The Board requests the consideration of the House of the following resolution:

106. Resolved, that Chapter V, Section 130C, of the *Bylaws* be amended by the deletion of the entire Section 130C, which reads as follows:

C. Committee on Constitution and Bylaws.

a. Composition. The Committee on Constitution and Bylaws shall consist of the members of the Council on Constitution and Bylaws of the Association.

b. Duties. It shall be the duty of the Committee to draft or approve the proposed text of all amendments to the *Constitution and Bylaws* prior to their submission to the House of Delegates for action; (2) to consider other matters referred to it, to hold hearings thereon and to report its findings and recommendations to the House of Delegates.

and be it further

Resolved, that Chapter IX, Section 10, be amended by the deletion of line 991, which reads as follows:

Council on Constitution and Bylaws

and be it further

Resolved, that Chapter IX, Section 110A, of the *Bylaws* be amended by the deletion of the entire Section 110A, which reads as follows:

A. Council on Constitution and Bylaws. The duties of the Council shall be:

a. To review the articles of the *Constitution and Bylaws* in order to keep them consistent with the Association's program.

b. To recommend editorial corrections in the *Bylaws*.

c. To act as the standing committee on constitution and bylaws during the annual session of the House of Delegates.

and be it further

Resolved, that Chapter VIII, Section 40A, of the *Bylaws* be amended by the addition of the following paragraph:

The Secretary shall draft or approve the proposed text of all amendments to the *Constitution and Bylaws* prior to their submission to the House of Delegates for action. The Secretary shall have the continuing responsibility for the review of the articles of the *Constitution and Bylaws,* recommend editorial corrections and suggest appropriate amendments when needed to keep them consistent with the Association's program.

Revision of Duties of Council on Dental Trade and Laboratory Relations—Amendment of "Bylaws": In its continuous review of the duties assigned to the various councils of the Association, the Board of Trustees has concluded that the revision of duties of the Council on Dental Trade and Laboratory Relations should be considered by the 1967 House of Delegates.

The relations between the dental trade and the Association are extremely cordial and in the establishment and maintenance of these relations the Council on Dental Trade and Laboratory Relations has had a very important role. The assignment of official liaison with the dental trade to the Council is now tending to restrict the contact of the dental trade with other agencies of the Association. The dental trade shares many interests with the Council on Dental Therapuetics, the Council on Dental Research, the Council on Dental Materials and Devices, the Divisions of Dental Research at the National Bureau of Standards and at the National Institute of Dental Research. The Board of Trustees believes that the dental trade should have access to all agencies of the Association with which it shares interest and that the single channel of liaison through the Council on Dental Trade and Laboratory Relations should be eliminated by amendment of the duties of that council as assigned in the *Bylaws*.

The Board of Trustees is also of the opinion that relations with the dental laboratory industry and craft at the national level require continuing and increased attention. For this reason, the Board of Trustees recommends that the duty of maintaining relations with the dental laboratory industry and craft be retained as the major assignment of the renamed Council on Dental Laboratory Relations.

The Board of Trustees is confident that the proposed changes will preserve and enlarge the very cordial cooperation which exists with the dental trade.

The following resolution is presented for the consideration of the House of Delegates.

107. Resolved, that Chapter IX, Councils, Section 10, Name, and Section 110, Duties, of the *Bylaws* be amended by deleting the words "Trade and" in the listing of Councils to make the amended line read as follows:

Council on Dental Laboratory Relations

and be it further

Resolved, that Chapter IX, Section 110H, Duties, of the *Bylaws* be amended to delete in item b the words "dental trade and" and in item c, to delete the words "dental trade and" to make the amended items read as follows:

b. To encourage and develop satisfactory relations with the various organizations representing the dental laboratory industry and craft.

c. To formulate programs for establishing and maintaining the greatest efficiency of the dental laboratory industry and craft in their relation to the dental profession.

Establishment of Bureau of Data Processing Services—Amendment of "Bylaws": Prior to the construction of the new Headquarters Building, the Board of Trustees authorized the initiation of a program to provide data processing services for all areas of Association activity. In January, 1967 the installation of a Honeywell H-200 computer system was completed. Priority had been given to the conversion of all membership record keeping to computer processing and currently all mailings to members, the recording of dues payments, the preparation of membership cards and other required reporting and analysis in this area are now automated.

The Department of Data Processing now has a staff of 15 persons and operates under the direction of the Secretary of the Association. Much of the personnel of the Department was secured by transfer from the Bureau of Membership Records.

Many other programs will be converted to computer processing as the schedule permits: the 1968 edition of the *American Dental Directory* will be prepared from tape processed by the computer. The scoring of all aptitude tests, the statistical analysis of many examinations of the Council of National Board of Dental Examiners, the processing of records for the Dental Research Information Center, the tabulating of contributions to the annual Relief Fund campaign, the preparation of the payroll and other accounting activities will be automated as soon as possible.

Computer time will also be available to outside agencies and income from this source for 1967 is estimated at $68,565, approximately 60 per cent of the total computer rental costs to date.

The Board of Trustees believes that data processing services will play an increasingly important and valuable part in the Association's program. The Board recommends, therefore, that the present Department of Data Processing be established, by amendment of the *Bylaws,* as the Bureau of Data Processing Services. In another section of this report, the Board of Trustees recommends the amendment of the *Bylaws* to eliminate the Bureau of Membership Records whose major functions have now been transferred.

The Board presents the following resolution for the consideration of the House of Delegates:

108. Resolved, that Chapter XII, Bureaus, Section 10, Name, of the *Bylaws* be amended by inserting as item B the words "Bureau of Data Processing Services" and by relettering in sequence the subsequent items, and be it further

Resolved, that Chapter XII, Bureaus, Section 30, Duties, of the *Bylaws* be amended by inserting as item B the following and by relettering in sequence the subsequent items:

B. Bureau of Data Processing Services.

a. To establish, maintain and operate data processing services for the Association.
b. To maintain the membership records of the Association.
c. To prepare and cause to be published the *American Dental Directory.*

and be it further
Resolved, that Chapter XIV, Publications, Section 60, *American Dental Directory* of the *Bylaws* be amended by the deletion of the words "Bureau of Membership Records" and inserting in lieu therefor the words "Bureau of Data Processing Services" to make the amended section read as follows:

American Dental Directory: This Association shall cause to be published an *American Dental Directory* under the supervision of the Bureau of Data Processing Services.

Elimination of Bureau of Membership Records—Amendment of "Bylaws": Because of the transfer of responsibility for membership records to the new Bureau of Data Processing Services, the Board of Trustees recommends that the sections of the *Bylaws* referring to the Bureau of Membership Records be deleted and presents an appropriate resolution.

The Board of Trustees wishes to advise the House of Delegates that membership promotion activities, particularly those related to dental student members, will be the responsibility of a new Department of Membership Development which has been established in the Office of the Secretary.

The Board of Trustees recommends approval of the following resolution:

109. **Resolved,** that Chapter XII, Bureaus, Section 10, Name, of the *Bylaws* be amended by the deletion of "E. Bureau of Membership Records" and be it further
Resolved, that Chapter XII, Bureaus, Section 30, Duties, Item E, "Bureau of Membership Records" be deleted in its entirety.

REPORT 4 OF BOARD OF TRUSTEES TO HOUSE OF DELEGATES: INCREASE OF ANNUAL DUES OF ACTIVE MEMBERS

The Board of Trustees presents Report 4 to the House of Delegates recommending an increase of $20 in the dues of active members, the increase to be effective January 1, 1969 if approved by the House of Delegates. In accordance with Chapter XVIII, Amendments, Section 20, Amendment Relating to Dues, of the *Bylaws* "an amendment to these *Bylaws* effecting a change in the dues of active members shall not be acted upon at the annual session at which introduced except by unanimous consent". The resolution proposed by the Board of Trustees, therefore, will not be considered until the 1968 annual session in Miami Beach.

The Board of Trustees requests that the proposed increase in dues of active members be discussed in the ensuing year by all constituent and component societies with a view to acquainting their members with the objectives of the Board in proposing this essential expansion of Association income by 1969.

In the balance of this report, the Board of Trustees presents comprehensive data

relating to the finances of the Association and to the current and emerging needs which dictate an increase of income from membership dues.

Record of Dues Increases: In 1950, the dues of active members were $12 a year, rising to $20 in 1951. This amount of dues was continued for nine years, until 1960, when an increase to $30 became effective. In 1964, dues were increased to $40, the amount in effect at the present time. A dentist holding membership from 1950 through 1967 would have paid to the Association the sum of $460 in annual dues, a little more than the self-employed dentist pays in Social Security Taxes, $422.40, *each year.*

Dues Paid in Other Health-Related Organizations: As a matter of interest, the following information on dues paid by members of health-related organizations is presented with the membership of each organization shown in parentheses followed by the amount of dues:

American Academy of Orthopedic Surgeons (3,900) $75; American Academy of Periodontology (1,203) $40; American College of Obstetricians and Gynecologists (11,035) $45; American College of Chest Physicians (8,000) $35; American College of Radiology (6,500) $55; American College of Surgeons (26,500) $60; American Medical Association (210,938) $70; American Osteopathic Association (9,847) $100; American Pharmaceutical Association (not stated) $25; American Society of Anesthesiologists (8,800) $75; American Podiatry Association (8,300) $100; American Medical Veterinary Association (18,500) $35; National Federation of Licensed Practical Nurses (27,684) $25; International College of Surgeons (13,000) $50.

Growth in Association Membership: The following table shows the consistent growth of Association membership since 1955. It should be noted that increases in active membership dues in 1960 and 1964 did not produce any reduction in membership—an argument perennially used against any proposed dues increase.

Active and Life Members, 1955-1966

Year	Members	Year	Members
1955	74,964	1961	84,813
1956	76,882	1962	86,551
1957	78,583	1963	87,842
1958	80,178	1964	88,938
1959	82,087	1965	90,264
1960	83,290	1966	91,875

Summary of Investment Data of Reserve Division, General Fund, 1952-1967: The following is a summary of the investment holdings in the Reserve Division of the General Fund for the period 1952-1967. The figures for 1967 are as of June 30.

It will be noted that the Reserve Division reached its peak in 1963 with $2,867,000 in securities at cost and $4,291,000 at market. The sale of these securities and capital gains of approximately $1,500,000 were applied to the construction costs of the new Headquarters Building.

The Reserve Division presently contains securities in the amount of $720,000 at cost and $947,000 at market. There are no plans for withdrawals from the Reserve Division at the present time.

Reserve Division of General Fund: Investment Data, 1952-1967

Year	Cost	Market	Excess Market Over Cost	Gain or (Loss)
June 30, 1967	$ 720,000	$ 947,000	$ 227,000	$
1966	720,000	912,000	192,000	(700)
1965	723,000	1,033,000	310,000	149,000
1964	1,536,000	1,961,000	425,000	1,187,000
1963	2,867,000	4,291,000	1,424,000	253,000
1962	3,055,000	4,343,000	1,288,000	53,000
1961	2,504,000	4,118,000	1,614,000	45,000
1960	2,126,000	3,209,000	1,083,000	(19,000)
1959	1,861,000	2,786,000	925,000	63,000
1958	1,872,000	2,755,000	883,000	5,000
1957	1,971,000	2,350,000	379,000	17,000
1956	1,902,000	2,478,000	576,000	39,000
1955	1,945,000	2,610,000	665,000	—
1954	1,950,000	2,439,000	489,000	—
1953	1,526,000	1,643,000	117,000	—
1952	1,119,000	1,217,000	98,000	—

Record of Annual Surplus or Deficit, 1950-1967: The following table shows the annual surplus or deficit as related to current annual dues from 1950 to 1967 (estimated). If the trend is continued in accordance with the pattern shown there will be a very small surplus or a deficit for the fiscal year 1968.

Annual Surplus or (Deficit) Related to Annual Dues, 1950-1967

Year	Annual Dues	Surplus or (Deficit)	
1950	$12	$102,300	
1951	20*	552,800*	
1952	20	440,600	
1953	20	499,900	
1954	20	415,400	
1955	20	405,600	
1956	20	322,900	
1957	20	188,100	
1958	20	164,000	
1959	20	(25,800)	
1960	30*	646,700*	
1961	30	580,400	
1962	30	356,400	
1963	30	198,800	
1964	40*	733,800*	
1965	40	659,100	
1966	40	203,600	
1967	40	26,340	Estimate

*Year following an increase in dues

Income for Period 1964-1967 (Estimated): Association income for the period 1964 to 1967 (estimated) is shown in the following table.

In the four-year period, total income rose substantially in the amount of $1,640,000. A substantial portion of this increase was derived from the new Headquarters Building as it came into full operation.

Income from membership dues has remained almost constant for the four-year period indicating that a significant increase from this source can not be anticipated without an increase in dues. As shown in the chart which is appended to this report, there is some reason for concern in the amount of Association income received from dues as compared to the amount received from all other sources. In 1964 and 1965, 67 per cent of total income was derived from membership dues. In 1966, income from dues dropped to 59 per cent of total income and a further drop to 51 per cent is projected for 1967. The per cent of total income obtained from membership dues is one of the critical factors in the legal determination and maintenance of the Association's not-for-profit status. The American Medical Association has recently increased its membership dues substantially in order to correct a similar imbalance in its source of total income.

Income for Period 1964-1967 (Estimated)

Income Source	1964 Actual	1965 Actual	1966 Actual	1967 Budget
Advertising				
Dental Abstracts	$ 8,863	$ 7,184	$ 7,677	$ 12,000
JADA	576,495	671,711	773,309	930,000
JOS	3,330	5,229	5,595	7,000
Building Income	—	—	417,406	850,000
Audiovisual	14,605	15,282	13,412	25,000
Library & Indexing	2,154	2,456	2,475	3,000
Dental Education				
Educational Meas.	138,005	142,709	154,913	155,000
Natl. Bd. of Dental Examiners	162,007	163,302	165,231	170,000
Div. of Dent. Hygiene	22,206	21,690	22,197	26,000
Earnings on Invest.	144,616	63,384	99,051	90,000
Exhibit Space Sales	183,125	175,825	229,145	250,000
Membership Dues	3,227,957	3,266,449	3,308,559	3,325,000
Miscellaneous Income	3,742	7,776	15,767	6,500
Overhead, Govt. Grants	—	—	22,270	80,000
Sale of Material	200,883	220,806	227,991	300,000
Subscriptions				
Dental Abstracts	41,424	41,757	43,592	47,900
JADA	42,636	45,478	55,757	64,100
JOS	41,755	45,154	46,452	46,000
Newsletter	1,964	1,862	2,224	2,500
Data Processing	—	—	—	68,565
Total	$4,815,767	$4,898,054	$5,613,023	$6,458,565

Expenses for Period 1964-1967: The following table indicates Association expense for the years 1964-1967, the last year being estimated. It will be noted that in the period covered, expenses for the construction and initial costs of the new Headquarters Building amounted to more than $2,100,000 of the $2,350,000 of the increase in expenses for the period. It should be noted that in this period, a substantial portion of the increased expense was devoted to the Association programs: $310,000 for Councils and Divisions; $155,000 for Bureaus and Departments. In 1967, $357,000 of the expense budget was earmarked for interest on the loan for the new Headquarters Building.

Expense Analysis for Fiscal Years 1964-1967 (Estimated)

Expense Item	Expense 1964 Actual	1965 Actual	1966 Actual	1967 Budget
Annual Session	$ 187,919	$ 116,424	$ 117,206	$ 109,150
Bureaus and Departments	720,263	773,831	805,682	876,665
Business Office	533,780	532,908	502,880	662,595
Central Administrative	359,915	421,055	470,685	565,015
Councils and Divisions	1,110,708	1,136,114	1,239,235	1,422,340
Elected Officers and Trustees	130,510	107,544	141,511	108,320
House of Delegates	43,085	49,052	50,997	47,590
Publications	809,407	875,671	820,507	856,285
Secretary	105,535	106,093	115,633	134,480
Washington Office	67,565	70,570	73,894	94,090
Treasurer	3,197	3,787	2,938	4,100
Contingent Fund	—	—	—	200,000
Building Expense	—	38,294	1,068,229	994,375
Interest Expense Building	—	—	—	357,220
Other	—	7,604	—	—
Total	$4,081,884	$4,238,947	$5,409,395	$6,432,225

Budget Requests and Appropriation for Fiscal Year 1967: In order to achieve a modest surplus in the budget for the current fiscal year, 1967, the Board of Trustees was compelled to reduce budgets requested by the various agencies by approximately $230,000. It should be noted that more than one-half of this reduction was made in the budgets of Councils and Divisions indicating that program activities of these important agencies had to be curtailed in order to bring the budget into balance.

Budget Requests and Appropriations for 1967

	Request	Budget	Increase or (Decrease)
Annual Session	$ 110,100	$ 109,150	($ 950)
Bureaus and Departments	889,665	876,665	(13,110)
Business Office	664,035	662,595	(1,440)
Central Administrative	573,290	565,015	(8,275)
Councils and Divisions	1,553,515	1,422,340	(131,175)
Officers and Trustees	110,320	108,320	(2,000)
House of Delegates	47,590	47,590	—
Publications	857,385	856,285	(1,100)
Secretary	134,480	134,480	—
Washington Office	94,590	94,090	(500)
Treasurer	4,100	4,100	—
Contingent Fund	200,000	200,000	—
Building Expense	1,068,000	994,375	(73,625)
Interest on Mortgage	357,220	357,220	—
	$6,664,400	$6,432,225	($232,175)

Number of Life Members: Both the Board of Trustees and the House of Delegates have expressed their concern from time to time about the growth of life membership programs in the Association and its constituent societies. A review of the growth in the number of life members gives no reason for the lessening of this concern. With the approval of life membership for 1,063 members at the 1967 session of the House of Delegates, the Association will be approaching the 10,000 mark—9,497 to be precise. The minor amendment of life membership requirements made by the House of

Delegates in 1966 (*Trans.* 1966:329) will have some effect on this trend but this will not be substantial.

The growth of life membership in the last ten years is reflected in the following table.

Number of Life Members, 1957-1967

1957	4,162	1962	6,538
1958	4,438	1963	7,055
1959	4,875	1964	7,490
1960	5,390	1965	7,877
1961	6,050	1966	8,434
		1967 (estimated)	9,497

The continued growth in the number of life members must necessarily bear some relation to the dues paid by active members.

Justification for Dues Increase: There are many major reasons why consideration should be given to an increase in active member dues at this time:

1. The ever-rising cost of goods and services.
2. The need to expand selected Association programs, some on an urgent basis.
3. The legal problem inherent in receiving only 51 per cent of total income from membership dues.
4. The problem of expending $70 for each active and life member while receiving only $40 from active members.
5. The limited opportunities for substantially enlarging non-dues income.
6. The necessity of initiating a program to restore the Reserve Division of the General Fund to a satisfactory level.
7. The desirability of amortizing the mortgage loan as rapidly as possible to diminish interest charges.

Rising Costs: There is no reason to believe that the costs of goods and services will cease to rise in face of current inflationary pressures. Congress is now legislating substantial increases in postage costs. The proposal of the Internal Revenue Service to place a tax on advertising will lessen net income from Association publications. Salaries will continue to advance in a difficult labor market. Printing, maintenance and other costs are bound to rise since they are tied in major part to union wage scales.

Expansion of Program: At its special meeting in March, 1967 the Board of Trustees identified many areas of Association activity which are in need of expansion, some on an urgent basis. Major activities to which new funding could be applied include: the accreditation activities of the Council on Dental Education to handle a rapidly increasing number of educational institutions especially in the field of auxiliary education; the improvement of communications with constituent and component societies through the activities of the newly established Department of Constituent Society Services; the desirability

of applying data processing procedures in more of the Association's programs; the ever-present demand for materials and services in the field of dental health education and public relations; the rapid expansion of the program of the Council on Dental Materials and Devices so that it is on a current basis in advancing dental technology; the critical need for establishing better relations with the dental laboratory craft and the possible establishment of a new Registry for Dental Laboratory Technicians; the full utilization of the research laboratory complex in the Headquarters Building; the publication of a newsletter for all members to improve communications; the maintenance and increase of support to the National Association of Dental Service Plans and the Joint Commission on Accreditation of Dental Laboratories; the expansion of dental programs and services in hospitals; the expansion of legislative activities and the Washington office staff as federal interest in health increases.

Relation of Membership to Total Income: At present only 51 per cent of total income is received from membership dues. The per cent of income received from membership dues is one of the criteria for maintaining tax exempt status. Confronted with a similar, or worse situation, the American Medical Association increased its membership dues from $40 to $70 in a three-year period.

Expenditure per Member: Each active and life member now benefits from the expenditure of $70 per member annually while active members pay only $40 in dues. This balance should be redressed to the point at which active members will be paying dues more closely related to the benefits received.

Non-Dues Income: While non-dues income has expanded on a very satisfactory basis in recent years, it is obvious that this expansion can not be continued indefinitely since the Association must be concerned about the number of its profit-making activities which can be said to compete with comparable commercial operations.

Reserve Division of General Fund: The Reserve Division of the General Fund which reached its peak in 1962 with a portfolio of $3,055,000 at cost and $4,291,000 at market was utilized in major part in the construction program. No contributions have been made for the past three years to the Reserve Division which now contains somewhat less than one million dollars, at market.

Amortization of Mortgage Loan: The amortization of the mortgage loans under an accelerated schedule would produce very substantial savings in the payment of interest. In addition, if the Association was full owner of the building six years after construction, the exposure to federal non-related business income tax would be entirely eliminated.

The Association's mortgage is divided into three loans, each with a different rate of interest. The cost of interest for all three loans over 20 years will be $4,369,440. If the mortgage is paid off in ten years, the interest cost would be $3,152,044; if paid off in five years, the interest cost would be $1,700,355.

The following is a breakdown of the interest costs for 20, ten and five years for each of the loans:

1. $2,000,000 at 4.875 per cent

Total interest amortized over following periods:

20 years = $1,135,000
10 years = $ 749,133.60
5 years = $ 428,264

2. $4.5 million at 5 per cent

20 years = $2,627,760
10 years = $1,958,990
5 years = $1,037,379

3. $1 million at 5.125 per cent

20 years = $606,680
10 years = $443,920
5 years = $234,712

Greater reductions in interest cost could be achieved by payment of substantial principal amounts. This possibility can be considered at a later date if the dues increase is approved. The prepayment penalties are not included in the material presented, but they would be of relatively insubstantial value in relation to the savings of interest cost.

Comment by Board of Trustees: On the basis of active membership as of December 31, 1966, an increase of $20 would produce new income for 1969 in the amount of $1,650,000.

As further experience on finances for the present fiscal year becomes available, the Board of Trustees will present additional information on this proposal.

110. **Resolved,** that Chapter I, Section 50A of the *Bylaws* be amended by the deletion of the words "forty dollars ($40.00)" and insertion in lieu therefor the words "sixty dollars ($60.00)" to make the amended section read as follows:

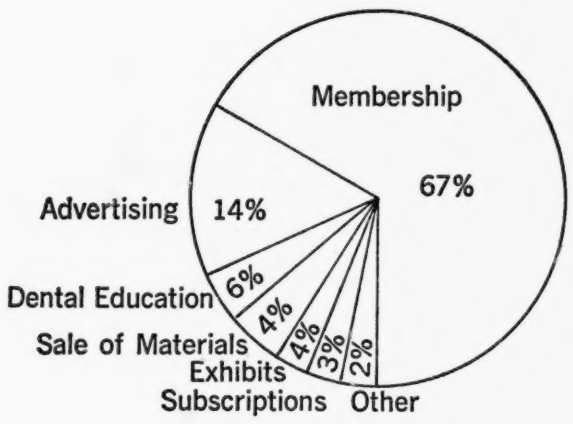
Active Members. The dues of active members shall be sixty dollars ($60.00) due January 1 of each year.

and be it further
Resolved, that increased active member dues become effective on January 1, 1969.

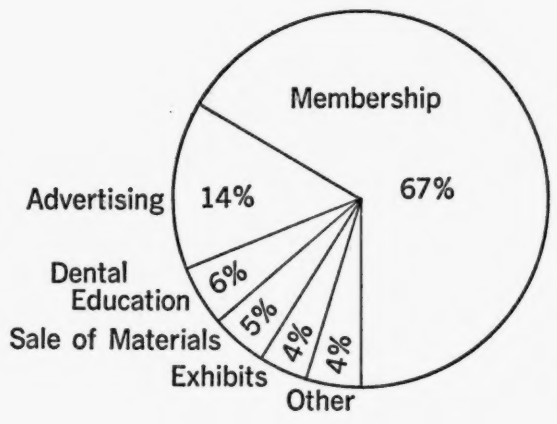
2

APPENDIX

American Dental Association
Income Distribution
1964-1967



1964



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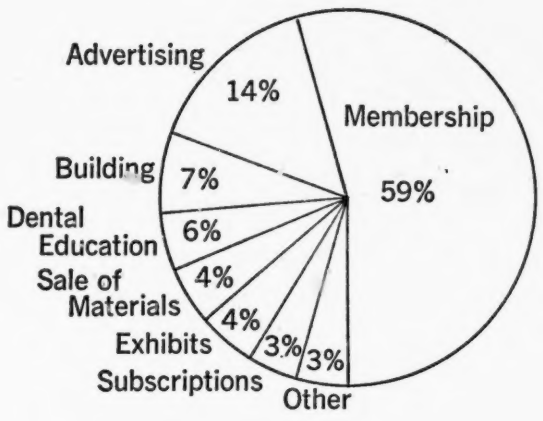
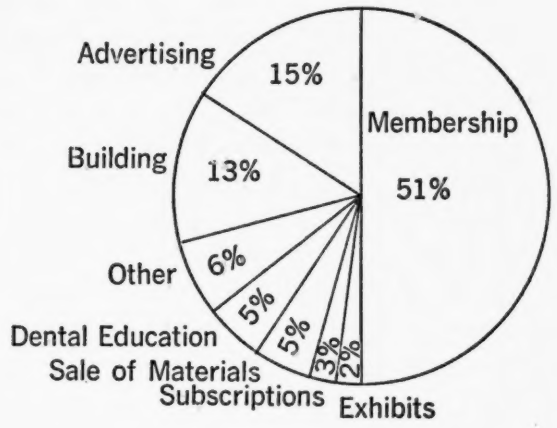


1966



1967